November 1960

Mental Hospitals

Hospital Journal
of the American Psychiatric Association

JOINT SETTING FOR RESEARCH:
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Mental Hospitals

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MENTAL HOSPITALS offers a forum for free discussion about matters of interest to persons involved in the care and treatment of psychiatric patients. Opinions expressed by the authors are theirs and do not necessarily represent the official policy of the American Psychiatric Association.

RECIPROCAL RELATIONSHIPS

Aid the Private Hospital and Its Community

By JOHN DONNELLY, M.D.
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The Institute of Living
Hartford, Connecticut

ALTHOUGH THE GENERAL HOSPITAL is accepted today as an integral part of the city or town, things were not always thus. Hospitals, until almost this century, were regarded with fear and repugnance and, indeed, as but temporary resting spots en route to the grave. Though the physicians, nurses, and other members of the staff were motivated by their sympathy for the seriously ill, their successes were lost sight of in the statistics of their failures.

With advances in medical knowledge, with upgraded standards of care, and with increasing success in its work, the general hospital has come to be viewed with different eyes. But public respect has been achieved not by these things alone. The hospital has had to be interpreted to the public; its staff has had to engage in community activities; the public has had to be brought into the hospital; and there has had to be development of services which interrelate with those in the community.

No general hospital could survive today without community support—on the levels of the Board of Trustees, the volunteers, the financial support, the recruitment of personnel, and the acceptance by the public as the place to go when professional advice recommends inpatient treatment. No matter how high the level of professional competence within its walls, the hospital achieves its fullest status only when the individual in the community knows its work and regards it with respect.

In the past few decades the mental hospital, both public and private, has been regarded by the public in much the same way as the general hospital was regarded in the last century. It has been isolated from the main stream of ordinary living—a receptacle in which were placed those whose absence would make life easier. The public hospitals, dependent on state and Federal financing, and built in remote spots, have been forced to operate on below-minimum budgets, and have not been accepted as an intimate part of the community health services. The private psychiatric hospital has been looked on as providing essentially individual medical services for a small selected group on the basis of financial ability, and thus beyond the financial capacity of the average citizen. Hostility, envy, and isolation became the accompaniments.

The isolation of the psychiatric hospital is still a major problem. The primary difficulty is to achieve integration with the community. However, the emphasis on emotional illness by the mass communications media has awakened considerable public interest in the mental hospital, and curiosity, always present, is now expressed openly. The community, hitherto ignorant of the hospital's work and fearful of association with it, no longer has a totally negative viewpoint. If advantage is not taken of this change, there is grave danger that in time the interest of the citizens will wane and the opportunity will have been missed. It behooves the psychiatrist, therefore, to examine what can be done to raise the status of the hospital—and the patient—in the public mind.

FLUCTUATING COMMUNITY RELATIONS

The history of the Hartford Retreat—The Institute of Living since 1943—resembles that of other hospitals in regard to the esteem of the surrounding community. When founded in 1824 as a nonprofit organization, it was the first hospital of any kind in Connecticut. Its origin arose in the concern of humane physicians and prominent citizens about the plight of the emotionally ill people of the state who suffered from the neglect customary in those days. Its establishment was sponsored by the Connecticut State Medical Society; the money was raised through donations from the medical society and private contributors, and a small grant from the State Legislature. (Indeed, a portion of the funds came from a lottery authorized by the Legislature.)

From the beginning there were both private and public patients; that is, all the mentally ill of Connecticut were treated here, private patients being financed by their families, and paupers by the state.

The hospital was held in high public esteem until about 1845 when disagreements arose between the super-

intendent and the Board of Directors on the one hand, and the State Legislature and administration on the other, over the financial contributions by the state for state patients. Private patients paid $3.50 a week, and the state would not pay more than $3. As a result the first state hospital was built for publicly supported patients and the Retreat received only private patients.

THE LOW POINT

In the following hundred years the relationship of the Retreat with the community fluctuated considerably, but with a primary downward trend. During this time, the physicians concentrated their attention for the most part solely on the care of their charges. But perhaps the lowest point in community relationships was reached between 1947 and 1955. In 1947, the Institute lost its tax-free status; when it appealed to the State Supreme Court for tax abatement, the Court decided that in spite of being a nonprofit, charitable hospital, the Institute was nonetheless subject to taxation. This situation was remedied in 1955 by the State Legislature, which restored the hospital to tax-exempt status as a nonprofit charitable organization.

It is clear that during those years there was a gross lack of public knowledge about the hospital and its work. It is also obvious that the staff was completely isolated from the community, and that the charitable services rendered to many individuals did nothing to help other citizens understand or know the Institute. A hospital cannot exist successfully in the midst of a hostile environment—it must draw nourishment from its surroundings. It must give, however, in order to receive. In 1944 at the 100th anniversary of Butler Hospital in Rhode Island, also a private psychiatric hospital, Alan Gregg, M.D., in his address, stated his belief that the community will support a private hospital if the hospital supports research, provides teaching, and engages in community practice.

Examination in 1951 of the role of the Institute in participating in community programs quickly revealed a real void despite a great deal of unpublished charity. Conversation with townspeople of different social and economic status revealed hostility, envy, misunderstanding, and a great deal of curiosity about this hospital isolated practically in the center of the city.

THE HIGH POINT

Yet the esteem and respect in which the Institute is held today are probably as great as at any time since its founding. Isolation has been replaced by integration, accomplished largely by the development of community-oriented programs involving many members of the staff at all levels and some even including patient participation. In the description of the associations developed with the community, there will be no consideration of the extensive professional participation in strictly medical and psychiatric activities, such as training courses for general practitioners of the county.

First, a word about the Institute of Living. A private, nonprofit hospital, the Institute has a 400-bed complement, though the census is rarely permitted to rise beyond 375. An educational center, the hospital offers a three-year accredited residency program, large affiliate and graduate nursing programs, and programs for the education of psychiatric aides. The internship training program offered by the psychology department is approved by the Education and Training Board of the American Psychological Association; the social work department undertakes field work instruction of students from the University of Connecticut, and the department of educational therapy, approved by the American Occupational Therapy Association, provides similar instruction and experience for students from a number of colleges. The patient population is drawn from a wide area and from every social class.

THE POWER OF THE PRESS

One of the earliest approaches the hospital made to the community was to the news media, the personnel of which share the interest of the general public in matters psychiatric. The local newspapers were invited to send a journalist into the hospital, with the agreement that if he saw a story, he would be at liberty to write as he liked. A reporter spent several days touring the hospital, speaking with anyone he wished, and having access to all administrative information. The series of articles which he wrote was the beginning of true public understanding. The newspapers, convinced that there exists a real desire on the part of the administration to inform the public about the activities of the hospital, are most cooperative. For the past eight years one of the local papers has cosponsored an annual series of public lectures given by members of the hospital's senior staff in a public auditorium in the city. These lectures always fill the hall, despite the fact that each one is reprinted in its entirety by the cosponsoring newspaper on the following morning. The 1960 addresses were reprinted in booklet form, and the newspaper reports that almost 20,000 requests for copies have been received. Many requests for appearances on radio and television are also received by members of the staff.

To deal with the innumerable solicitations by organizations of all kinds, a "speakers bureau" is maintained to coordinate speaking engagements before men's service organizations, women's clubs, P.T.A.'s, and professional groups of a wide variety. Members of the staff —not only the medical staff—are encouraged to speak on appropriate topics. Within the hospital, the resident or fellow is expected to participate in lectures and seminars to aides and nurses and in other inservice training programs; this helps him to develop both teaching and speaking skills. When he has shown the capacity and the interest, he is encouraged to give talks to outside groups, thus developing confidence and experience in public-speaking, and learning the value of physician-participation in community affairs.

Letting the public know is, of course, not enough. The provision of professional services must be undertaken. Returning to a practice reminiscent of the distant past, the Institute arranged with the State Department of Public Welfare to accept disturbed adolescent boys

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*Stieglitz, E. J., in Handbook of Nutrition, ed. 2, New York, Blakiston, 1951, p. 337.

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and girls at greatly reduced rates. These patients are integrated into the treatment programs without any distinction as to social background or financial situation. In fact, the Institute, where necessary, provides a weekly allowance from its own funds in order that a youngster may feel able to participate with other patients without embarrassment. The introduction of these welfare-sponsored persons into the ordinary private population has had interesting effects both on them and on others with very different social origins. The number of patients involved is relatively small, but the personnel of the local and state departments of public welfare find it reassuring to know that they can place disturbed adolescents in a suitable local hospital instead of having to send them to institutions in other states.

The hospital operates two outpatient clinics, established at first on a part-time, but now on a full-time basis, one for adults and one for children. The children's clinic has contributed greatly to the improved community climate. The clinic itself fulfills two functions—giving psychiatric residents the opportunity to obtain experience and training in pediatric psychiatry, and providing diagnostic, consultative, and treatment facilities for parents and children of the community. The clinic works at capacity and is planning to expand its services. As part of a research project, a nursery school for normal children will be established in the fall of 1960, running parallel with the therapeutic group for autistic children which has been in operation for some years.

COOPERATION WITH SCHOOLS

When the psychiatric consultant to the Hartford school system resigned, an arrangement was made whereby one of the clinic psychiatrists sets aside four hours a week for cases referred by the Guidance Bureau of the Hartford Board of Education. The director of the bureau may refer any school child who he feels is in need of psychiatric examination. The child, the school social worker or psychologist, the teacher, and the parents may all be seen individually or in selected groups. If it seems indicated, the child may be accepted for treatment in the children's clinic. Because many of the children may be referred to the clinic independently, this arrangement insures that a considerable work-up and body of information are available when the child is first accepted, while excellent follow-up services are available.

Largely as the result of the close collaboration of the Institute with the schools, many of the patients of high-school or college age are able to pursue their studies without a hiatus. In the rehabilitation program, great emphasis is placed on educational activities, including academic subjects. Special attention is paid to the continuation of the academic curriculum of all young patients of school or college age, and many take correspondence and university extension courses. The academic staff of the hospital is augmented by teachers from the local public school systems, who come into the hospital to teach Connecticut students. Salaries are met by the local and state education departments, while for patients from out of state, similar resources are available on a fee-schedule. Connecticut patients of high school age, may, if they are able, attend the public high school without charge. Again, patients from out of state may do so at a standard fee set by the local authority.

Close working relationships with the local education systems are furthered by the participation of the professional staff in lectures; for example, addresses to teachers of a whole school system, or to the staffs of individual schools. Graduation addresses, lectures to the student body on the relation of psychiatry to other sciences and to the social studies, and sessions with individual classes are not uncommon. One school asked recently for a staff member to speak for two hours to two groups of "accelerated students" aged eleven and twelve, on mental health aspects which would be appropriate to the age and comprehension of the pupils.

RECIPROCAL EDUCATION

Trinity College and the University of Hartford are within the boundaries of the city, as are some of the schools of the University of Connecticut. Patients, when they are well enough, attend courses at these institutions and, in turn, several members of the Institute staff hold part-time teaching appointments at these schools. A number of the part-time teachers who visit the hospital are drawn from the predoctoral students at these colleges; most popular among the courses offered are architecture, foreign languages, and mathematics.

To avoid institutionalization, it is important for patients to go into the community as soon and as often as possible. They are therefore encouraged to visit local cultural facilities, in connection with the avocational aspects of their rehabilitation program. Because the benefits of downtown visits are greatly enhanced if linked with work which the patient feels to be useful, the social service department helps them seek community activity with a real purpose. This may include attendance at business or vocational courses, part- or full-time employment, or work in a volunteer capacity with some of the many nonprofit, charitable, social, educational, and medical agencies in the city. Where possible, such activities are linked with the long-range program the patient is to follow on his return home. Patients often provide valuable assistance because of special talents, because an agency has budgetary limitations, or because it has a peak period of activity which calls for additional help. Among agencies which have welcomed the opportunity to use patient help are The Children's Museum, The Newington Home and Hospital for Crippled Children, the Atheneum (a private art museum), and the Visiting Nurse Association. Even patients not yet ready for outside activities feel a sense of purpose when organizations want volunteer help in stuffing envelopes and so on, at fund-raising times. The material is brought to the hospital and the agencies' own volunteers or personnel work alongside the patients. Other activities for patients without town privileges include performances and demonstrations by such groups as the Hartford School of Music, local theater groups, an unusual carillon group, and others.

Most psychiatric hospitals, large and small, public

and private, need the services of vocational guidance specialists, for testing and for other purposes. Yet the number of patients requiring such specialized skill at any one time may not be large enough to justify full-time employment of such personnel. Suitable arrangements may often be made by state hospitals to use the skills provided by other government departments, such as the Bureau of Vocational Rehabilitation. The Institute has been able to make a very satisfactory arrangement with the Vocational Guidance Bureau of the local Y.M.C.A.

THE ONUS IS ON THE HOSPITAL

Such mutually beneficial collaboration does not spring up spontaneously. It is up to the hospital psychiatrists to make the initial approaches to bridge the gap between the mental hospital and the townspeople. Establishing contact with a community resembles in some ways the same process with a patient. Approaches must be made not only through the social work staff, but also through contacts by other members of the hospital staff during their work with community agencies. Employers, at first reluctant, may be willing, because of personal acquaintance with a staff member, to experiment by hiring a patient on a trial basis. Careful selection of the patient is necessary to establish confidence, but once this is achieved, each such employment represents another mutually satisfactory service. Nor must one overlook the public education value arising through patient contacts in shop, office, or garden nursery.

With careful consideration a psychiatric hospital can provide many services to community agencies. For example, visiting or public health nurses are frequently faced with problems having an emotional origin. The opportunity to discuss these with a psychiatrist is most valuable. A group of nurses from the Visiting Nurse Association attends sessions at the Institute on alternate weeks, to talk with a third year resident about problems encountered in their work. For several years now, all candidates for ordination by the Episcopal Diocese have been evaluated in the adult outpatient clinic of the hospital, and professional consultation has been made available to a Catholic home for delinquent girls. A staff psychiatrist serves with the Social Adjustment Commission, a governmental agency of the City of Hartford, and lectures have been given to members of the police force on such topics as the management of disturbed and upset persons, delinquency, crime, and the abuse of narcotics.

Making the hospital facilities available to community organizations has proved an important step in achieving community understanding. As part of a new rehabilitation building, a 200-seat auditorium was constructed with the twin objectives of meeting internal hospital needs and being available to local organizations for their meetings. A variety of citizens' groups and professional bodies have made use of this. Frequently, an address by a staff member is requested. Combining this with a tour of the hospital—always dividing the visitors into small, relatively inconspicuous groups—has been influential in destroying many of the myths, and in changing attitudes, not only toward the Institute, but also toward psychiatric illness and psychiatric patients. Opening the mental hospital to visitors has been successful in helping to change public attitudes throughout the country.

The provision of physical facilities may be of vital importance to new organizations or agencies, especially before their finances are assured. Offices and other facilities have been made available under such circumstances. The local Mental Health Association and the local Association for Retarded Children were given space in the early stages of their development; the latter set up its own school until the local education authority made provision within the public schools. An experimental interdisciplinary agency, the Social-Legal Counseling Board, used offices in the adult outpatient clinic during its four-year existence. At the last session of the State Legislature, because of the pressures of the parents, the responsibility for the care of mentally retarded children was placed on the Department of Health rather than on the Department of Mental Health. The Institute nevertheless has been approached, with the knowledge of the parents, about the possibility of establishing an evaluation clinic for retarded children.

DE-ISOLATION HAS ITS PROBLEMS

The hospital has cooperated with a number of other groups—the courts, business and industrial houses, the city, and the state. It has joined with nearby institutions —the Hartford Hospital and Trinity College—to study the neighborhood within which all three are situated, for the purpose of initiating programs to prevent deterioration of the area while a vast municipal redevelopment is proceeding in the center of the city.

In course of time, the psychiatric hospital develops countless ties with different sections of society—government, both local and state; schools, public and private; industry; law enforcement; churches of all denominations; and private organizations. In spite of this great variety of contacts and the many community services which the hospital develops, one must always be prepared for the continuance or even the appearance of ambivalent reactions. One becomes aware of a type of situation comparable to the "town-and-gown" problems of a university city, or to those of the large clinic in a small town. The source of the difficulty is to a large extent the reversal of the previous isolation. Not all such ambivalence is easily resolved, though efforts must be continued to bring understanding and interpretation of the work of the hospital. The aim must always be to understand the origins of the difficulty and by personal contact to eliminate as much misunderstanding as possible.

That a tremendous amount of voluntary effort is involved is beyond question, but when a large group of persons share in it, much can be accomplished. When members of the staff become active members of the community, and when the community services are interrelated with those of the institution, the psychiatric hospital ceases to be just an organization—and a mysterious one, at that—and becomes an integral part of the community. •

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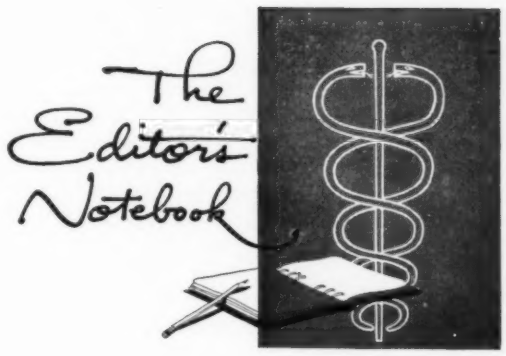

I CANNOT HELP BUT REMARK upon the fact that psychiatry has apparently embarked upon an era of enthusiastic, vigorous, optimistic, and bold experimentation. This wave of optimism affects our language, our outlook, our planning priorities, our work habits, our hopes, and our expectations.

For an especially poignant example of dauntless hope and enthusiasm, note how the large public mental hospitals are seeking to impart some of the desirable characteristics of the small hospital to the behemoths they have inherited. The hospital at Clarinda, Iowa, (Page 30) for example, has been reorganized into several administrative units so that a patient, from admission through discharge and rehabilitation, is kept with other patients from his own county and treated by the same psychiatric team throughout. Pilgrim State Hospital (N.Y.), the largest hospital in the world, is reorganizing into smaller independent administrative units. In effect these people are saying, "We may not be able to dispense with our multi-million-dollar investment in physical plants, but that's no reason why we can't *operate them* in the manner of a smaller hospital."

Listen also to the commissioners and other leaders in state mental health and hospital systems. In Colorado, Dr. Franklin Ebaugh tells us that it is now possible to "reverse the irreversible"—that is, to reverse both the course of a patient's illness and the limitations of society's attitude towards it. This we can do, he says, by reactivating what has been a "dead zone," the "vast area of untapped resources in the community," which can now, at long last, be harnessed. For Arkansas, Drs. Granville Jones and Hayden Donahue have crystallized a bold new plan for a "continuum of mental health services," which envisages several "perimeters of defense" against mental illness in the community, all of them revolving around the nucleus of a state mental health center which will serve as a research, training, and coordinating agency.

Dr. Daniel Blain, former A.P.A. Medical Director and now Director, Department of Mental Hygiene of California, has been for years a kind of psychiatric St. Paul, preaching that we can avoid construction of more large public hospitals by developing community resources. He is proceeding to show us how in California.

A recent progress report on Massachusetts by the commissioner Dr. Harry Solomon, is replete with such phrases as "a new era has arrived," "at long last a breakthrough has occurred," "we can prophesy an even better outlook than we now have." In Missouri where massive public backing has been mustered for his newly formulated long-range program, Dr. Addison M. Duval tells us that "the mental health climate is one of optimism and enthusiastic support."

In almost any state, we find the anticipation of excellent things to come. At a national level, the final report of the Joint Commission on Mental Illness and Health, soon to be published, will reflect the spirit of this wave of the future.

We in the A.P.A. Central Office are planning how we can be of the greatest help in the hospital field in this era of changing needs and practices. It is generally appreciated that the A.P.A., through its inspection and rating services, its standards, its institutes, conferences, and publications, contributed much to the great achievements of the Fifties: bringing minimally adequate levels of humane treatment and care to mental hospitals the nation over.

But the standards of the Fifties and the inspection and rating services that went with them no longer meet the needs of the evolving hospital-community psychiatry of the Sixties. Already the A.P.A. Committee on Standards and Policies of Hospitals and Clinics has developed a project looking to their reformulation. This fall the Central Inspection Board will shift its focus. In its stead a new Professional Service section will be established as a part of the A.P.A. Mental Hospital Services in the Central Office.

This section will be headed by a full-time psychiatrist, experienced in community psychiatry and in the administration and problems of the "mental hospital in transition." The greater the ground swell, the more numerous the ideas, the greater will become the demand for vigorous leadership. Psychiatry will call for integration of creative efforts, and searching examination of each new program in relation to the over-all picture. It will demand opportunities for consultation, for advice, and for education. It will call for revaluation of standards and policies, discussion of movements of national significance, and the provision of additional services, not only to hospitals, but also to newly created mental health facilities of all types.

I cannot, however, write a detailed job description for the Chief of the new Professional Service of the A.P.A. Mental Hospital Services. It will be largely up to him to create the climate in which to implement this magnificent opportunity. I can only say that he will have one of the most important roles in hospital psychiatry today. I know—we all know—that he must be a dedicated, knowledgeable man—fresh in vision, but seasoned by experience. There are many such in our profession. We will find the one best fitted to meet this challenge.

Matthew Ross, M.D.

Number Three in a Series by Past Presidents of A.P.A.

SPECIFICS FOR DE-ISOLATION

By GEORGE S. STEVENSON, M.D. (1949-50)
The National Association for Mental Health, Inc.
New York, N. Y.

IN RETROSPECT, it is easy to see that the large mental hospital was, through its very evolution, almost inevitably destined for a life of isolation. The earliest care of dependent persons, apart from legal offenders, was in paid foster homes, chosen because they were low bidders for the dependent's care. The establishment of the county almshouse was an attempt to reduce the possibilities of exploiting the dependent, but counties were larger and more sparsely settled then, so that the almshouse had to serve a larger area. Putting the patients under one roof took them further from home and made their care less personal. It was also harder for friends and relatives to visit. Six miles by farm horse was the equivalent of 30 miles by today's transportation. Thus was isolation unwittingly engendered.

The provision of state hospitals specifically for the mentally ill likewise was done for a humane purpose—that of supplying scientific service by trained staff. But it also entailed a loss, in that distances were still further increased and isolation aggravated.

SELF-CENTERED ADMINISTRATION

As these hospitals increased in size, the administration became more and more self-centered. Services were not extended beyond the hospital walls for, until the turn of the century, slow transportation and poor communication militated against outside involvements. Such extramural services as did exist were not attuned quantitatively or qualitatively to the needs of hospital patients, to say nothing of those of prospective patients or former inpatients. Thus administrative convenience, added to physical isolation, produced an increasing discrepancy between the actual practice of public psychiatry and the total medical needs of the mentally ill.

Isolation was further abetted by the concept that the mentally ill were, *ipso facto*, incompetent. Thus, little value was seen in attempting to preserve the patients' community ties. Such activities as attending church, shopping, transferring property, voting, and working were neglected even for patients who could perform these functions as rationally as could the general population. Patients were committed to the hospital as a danger to themselves or to others. Later they were released on what was called "parole," even though they were still considered legally dangerous and had full freedom to convert this danger into a deed. The hospital retained its authority over such patients; but it neglected to assume the commensurate responsibility of protecting the public and meeting the patients' needs.

Recent developments in psychiatry are making isolation an anachronism. Today the increase in discharges and conditional discharges magnifies the hospital's stake in and dependence on the outside community where more and more of its patients are living. Either there must be close collaboration with local physicians and other community agencies, or the hospital must extend itself into the community by means of extramural services. Veterans Administration hospitals, with their extensive territories, have the greatest difficulty in relating with the community. The state hospitals are in some ways more fortunate, because, on the average, their districts are smaller. Even at that, their districts are too large because the hospitals themselves are too large. Today there is a trend toward reducing these oversized hospitals. Condemned dormitory buildings are not being

replaced. In this way we try to create smaller units more closely related to the smaller communities they serve. We are also aware that liberalization of hospital function, especially through the use of the open ward, can succeed only where there is a close relationship with the surrounding community.

Nowhere do we have a model hospital embodying all the features that help overcome isolation. But we can list an impressive array of such features that are in effect here and there and that could be applied, in one way or another, to nearly every large mental hospital.

One group of programs is especially valuable in bringing the community into the hospital. Most important among these is the use of volunteers. Not only do volunteers help with direct assistance to patients by services such as recreation and education, but they symbolize to the patients the living interest of the community. They provide for the patient a realistic and encouraging miniature of the society to which he will return. They also bring back to the community an appreciation of the hospital, its contributions, and its problems. The danger is that volunteers may become too identified with the hospital as it is, and so overprotective that they try to conceal its deficiencies.

Visits by friends and families afford some of the same advantages as do the volunteer programs. More specifically valuable is that they maintain family relationships, and so facilitate early discharge. If the hospital is truly guided by the patients' needs rather than by administrative convenience, there can be no strict rules and routines about visiting, because each patient's needs differ.

Specialist consultants from the community are appointed, of course, for clinical purposes; but they too serve as emissaries from the community to the hospital, and return to their homes and offices with a more realistic view of the hospital itself.

TANGENTIAL SERVICES

These three groups—volunteers, visitors, and professional consultants—influence patients directly and thus share in hospital functions; there are other groups which assist in specific ways without actually entering the hospital itself.

Professional persons in the community, who follow-up discharged or conditionally discharged patients, feel that they are a part of a hospital-community effort on behalf of the patient. This type of follow-up, just beginning, is an especially significant contribution. In some areas it has resulted in the establishment of mental health centers, in which the state's task of restoring or protecting mental health is shared with local physicians and agencies.

State vocational rehabilitation and state employment services could reduce isolation if they were tied into the hospital rehabilitation program much more intimately than they are at present. In but few states do counselors from these agencies visit the mental hospitals at regular intervals to help plan for patients. No hospital has enough of such counseling.

When it comes to prevention, much depends on cooperation with the communities. The hospital learns from its patients some things which could and should have been done to insure early treatment, and others which might reasonably have been done in the effort to avoid mental disorder. These things cannot be done by the hospital itself. But the hospital, by interpreting them to local authorities and offering its professional assistance, reduces its isolation and assists such authorities to institute preventive measures.

DISSATISFACTION BREEDS TENSION

Another group of programs includes activities which indirectly help to overcome isolation by helping the staff to get away from the hospital, and to spend some time in the community. Well-known hazards of institutional living are the constriction of professional perspective, and the failure to achieve the satisfactions which come from a broader expression of life-values and role-concepts. Dissatisfactions find expression in tensions between staff members.

Traditionally the social service staff is supposed to be the community arm of the mental hospital. Too often, however, the social service staff is so overloaded that it is not able to exert sufficient influence on the rest of the professional staff. To really assist in overcoming staff isolation, the social service staff has to be large enough to give the patients the service they need, and to have sufficient time to integrate its operations closely with those of the medical, nursing, and other staff of the hospital.

In considering extramural staff activities, one first thinks about the outpatient clinic. Such work provides both professional and personal satisfactions, offering as it does clinical experience in neuroses, childhood disturbances, marital counseling, and the like, not commonly called for on the inpatient service.

Professional isolation can also be mitigated by the offering of staff consultation to community agencies (judicial, educational, health, and welfare). Such assistance is needed by agencies not only in the immediate vicinity of the hospital, but in all the communities from which patients come. It is especially needed by communities which have no psychiatrists of their own. Such activities, as well as insuring treatment during the earlier phases of psychiatric disorders, serve to give the hospital staff a broader appreciation of the human problems encountered by community agencies.

There was a time when transportation problems forced most of the hospital staff to live on or near the hospital grounds. Today, if the hospital is well planned and situated, the staff can reside in normal communities, and participate in community activities with fellow citizens. These neighborly associations help to remove some of the mystery that has blocked aggressive attack on the hospital's deficiencies.

OUT OF SIGHT OUT OF MIND

The causes of isolation are not found solely within the hospital. The general public also contributes. It is easier for the public to neglect its responsibilities when it is

protected from seeing the results of this neglect. But when staff members of the hospital are neighbors of the citizenry, this conspiracy of isolation is more difficult to maintain.

RESEARCH AND TRAINING

A final group of "de-isolation" techniques involves both the extension of staff function to the community, and the bringing of the community into the hospital. Formal liaison of the hospital with research centers is extremely valuable in this respect. Joint arrangements between hospital, outside clinics, and educational institutions for professional training are also effective. The Veterans Administration hospitals, badly isolated before World War II, today offer an outstanding example of the value of such research and training partnerships. General hospital staff members, too, have much to contribute to the professional program of the mental hospital, which in turn can give valuable service to these community hospitals, especially in areas with no local psychiatrists. Arrangements for such exchanges have proved feasible and effective.

Recent years have seen the development of many supplementary methods of caring for psychiatric patients, notably part-time hospitalization. Day-, night-, or transient-hospital treatment not only serves many patients' needs more exactly, but also brings the hospital into closer touch with the community. Family care offers similar values. Mental hospitals which lack local facilities for post-discharge treatment or follow-up (notably VA and private hospitals) can discharge patients earlier and relate their work more closely to the community if they can arrange for the necessary post-hospital care to be done by state or local hospitals, clinics, public health nurses, welfare departments, and the general practitioners.

There are, of course, many other arrangements which can help to bring the hospital out of its isolation. Those which have been presented above have the added advantage of improving service to patients, as well as being antidotes for isolation. •

WANT TO BE A PROFESSOR?

By DR. WHATSISNAME

TODAY EVERYBODY TALKS ABOUT TEACHING the general practitioner. But with Blue Cross paying the bill, almost every bed-occupant in a general hospital is a private patient—not to be displayed to students. However, when it comes to teaching psychiatry to GP's, there is a huge reservoir of clinical material at hand in every public mental hospital. Here's a chance for a combination of imagination, leadership, self-interest, and community service. *Imagination* is needed to see how our kaleidoscope of patients can illustrate the many aspects of emotional illness. *Leadership* is what it takes to organize and promote courses for general practitioners. Since this activity will bring favorable attention to the mental hospital, it has a *self-interest* feature, too. And the *community-service* angle is obvious. Indeed the public mental hospital is a wonderful warehouse of teaching material not only for M.D.'s but also for clergymen, social workers, educators, psychologists, and even (why not?) personnel officials.

Lots of public hospitals will say, "good idea . . . for somebody else. We're understaffed." But this is one activity on which staff is willing to put in some overtime and extra work. Also, a dynamic hospital leader can recruit teaching help from private practitioners, general hospitals, and medical schools. Almost any A.P.A. District Branch would like to take this on as a project, too. After all everyone wants to be a professor.

Nothing like having some inquisitive students of any age to ask questions. It's the best brain prod known to man. An educational program provides an intellectual ferment that will keep everybody's wits sharp. Pardon the mixed metaphor—maybe ferments don't sharpen things, but at least they keep the intellectual pot bubbling, and that's all to the good. Any takers?

Summer Employees Work Their Way Through College

By RICHARD C. RYNIKER, Ph.D.
Management Analyst
VA Hospital, Lyons, New Jersey

THE CURRENT VETERANS ADMINISTRATION POLICY of employing third- and fourth-year high school students, undergraduate college students, graduate students, and medical students as temporary summer hospital employees has two basic purposes. First, the hospital is able to secure temporary personnel for the summer, and second, it is developing a potential source of career employees. The plan benefits not only the students and the VA, but ultimately all of society.

The students gain additional income for the continuation of their education, and at the same time receive orientation in the medical field through actual, daily, on-the-job experience. Their assignments are based on the needs of the hospitals and the students' qualifications and vocational objectives. Since regular, full-time staff members prefer to take their vacations during the summer, there is a real need for replacement employees at the very time when these students are available. The students themselves welcome the opportunity of working in a medical or related setting, as they can obtain practical experience not available in a classroom; here is a realistic test of their vocational aspirations.

The VA conducted a survey of twenty-three representative hospitals of all sizes (160 beds to 1900 beds) to determine the extent and diversification of student employment. Of fifteen general and surgical hospitals studied, five were utilizing student help in 1959, and this number jumped to nine in 1960. Of six neuropsychiatric hospitals, three used summer students in 1959, and by 1960 all but one were employing these students. The two tuberculosis hospitals did not hire students either year.

The survey also showed:

—That encouragement and strong backing of the program by the governing body of the hospital or hospital organization is extremely helpful. The "front office" should actively foster this use of students.

—That the program is now more frequently used in medium (500-1000 bed) and large (1000-2000 bed) hospitals rather than in smaller ones. This would seem to be a contradiction, since the larger the staff available, the more easily regular employees' off-duty time can be absorbed. However, one possible reason for the restricted participation by small hospitals may be the difficulty of supervising student employees in the absence of the regular staff members. Another reason may well be the relatively tighter budget situations of the small hospitals. The cost of the students' salaries constitutes a much larger percentage of the over-all budget of a small hospital than of a medium or large hospital.

—That the program is growing very rapidly, both in numbers of students employed and in the types of assignments. As these hospitals gain additional experience, the degree of responsibility given the students is also being expanded.

In the summer of 1959, only eight of the twenty-three hospitals studied used students, whereas during the past summer, fourteen were using students. Only one hospital which had employed students in 1959 did not hire them in 1960. Three of the five large outpatient clinics studied were using students in 1960, and a fourth clinic was seriously considering their use.

The VA has set up a regular orientation plan for these summer employees, which is implemented by each participating hospital. Herein a student receives classroom instruction comparable to the regular employee orientation. Then when he is assigned to a specific job, the student receives a second orientation in that particular area.

In 1959 a total of 51 students were participating in the program in the hospitals studied. They were distributed throughout 13 different types of services, the largest users being the clinical laboratories, with thirteen temporary summer employees. Physical medicine and rehabilitation used eight, and recreation, five.

In 1960 the total number of students jumped to 80, and they were distributed throughout 22 different services. The largest user was general research with ten. Dietetics service had nine students; clinical laboratories, eight; physical medicine and rehabilitation, ten; and recreation, seven. Also, three new major categories were added—nursing, psychiatry, and psychology.

The majority of students in the program are from undergraduate and graduate college levels, because of the greater skills and talents they can offer, and because of their more firmly established vocational goals. The VA "youth volunteer" program provides for high school students a medically-oriented environment compatible with their interests, skills, and availability. This younger group constitutes an excellent source of pre-oriented summer employees when they reach college level.

STUDENT HOURLY PAY SCALE

Completed third year high school	$1.43
High school graduates	$1.57
Completed first and second year college	$1.69
Completed third year college	$1.81
Completed fourth year college	$1.95
Postgraduate students	$2.16

Appraisal of this program shows that it is successful, and is growing appreciably. There is every indication that it will continue to grow in direct ratio to the availability of funds for the program. Competition for student summer employees has not yet become a problem but probably will become so in the future, especially for the services of the third and fourth year college undergraduates, graduate students, and medical students. •

By SISTER M. ELECTA BYRNE, O.S.B., M.A.
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A PSYCHIATRIC UNIT
Enters Its Second Quarter-Century

"A psychiatric unit affords a place where the physician may take his patient for study and consultation with the psychiatrist without the social stigma so often attendant upon residence in a psychiatric hospital. Such patients will probably be studied earlier in their disease and thus assisted to earlier recovery.

"Not only the patient who enters the hospital with a diagnosis of mental disease, but many other patients, need psychiatric care. All patients become more or less emotionally upset in illness, and one must expect the consequent reactions. In a hospital with a psychiatric unit, all doctors and nurses are better prepared to cope with such situations. Such a unit serves as a center where research in psychiatric medicine through contacts with other medical staff members studying their own cases serves the community in the promotion of health.

"The modern hospital should be a health center providing diagnostic and therapeutic facilities for all who come to be served. To exclude mental disease is to fail to measure up to this standard."

These words were written in 1946 by the late Sister M. Patricia,[1] former administrator of Duluth's St. Mary's (General) Hospital. Certainly these were progressive thoughts 14 years ago, yet they were based not upon mere hopeful expectations, but upon actual experience in the successful operation of a psychiatric unit, then already 12 years old.

A BEGINNING OF THOUGHT AND ACTION

During the early Thirties, when scarcely half a dozen voluntary general hospitals in the United States had psychiatric units, St. Mary's was pioneering the establishment of just such a service. Sister Patricia, along with Dr. L. R. Gowan, one of Duluth's first psychiatrists, who was also on the staff of the hospital, had long recognized the significance of a psychiatric unit in the total program of mental care. They were committed to the principle that mental illness is as much a responsibility of the general hospital as is any other type of illness. Consequently, in 1934, through their combined planning and efforts, St. Mary's opened an 11-bed closed psychiatric unit.

At the time, alterations and improvements were in progress throughout the entire hospital, and with a few structural changes, one first-floor wing was completely closed off from the rest of the hospital. The combining of an adjoining clothes room and an unused elevator area gave the unit a recreation room, and a continuous-tub room was added shortly thereafter. Still later, the hospital made rooms available in a medical-surgical section on the adjacent first floor for psychiatric patients who did not need the protection of the closed section.

The first supervisor was a graduate nurse from St. Elizabeths Hospital, Washington, D. C. Nursing students (both the three-year diploma students and the degree students from the Department of Nursing, College of St. Scholastica, Duluth) were required to spend 12 weeks on the unit as part of their basic education and experience. Psychiatric clinical instructors with Masters' degrees and specialized training directed the educational program for these students and supervised their experience. From its inception, the department also included such services as social work, clinical psychology, occupational therapy, and physical therapy.

After World War II, more psychiatrists established practice in Duluth and began bringing their patients to the hospital. With the medical profession's increasing understanding of the part that emotional factors play in the etiology of mental illness, interest increased as to what psychiatry had to offer. The number of psychiatric consultations rose and the medical and surgical staffs accepted the unit enthusiastically. General practitioners began admitting patients to the unit, and, as a rule, psychiatric consultation was requested. Nurses in the general hospital wanted to learn more about the emotional components of illness, and they added related talks and discussions to the agenda of their staff meetings. As

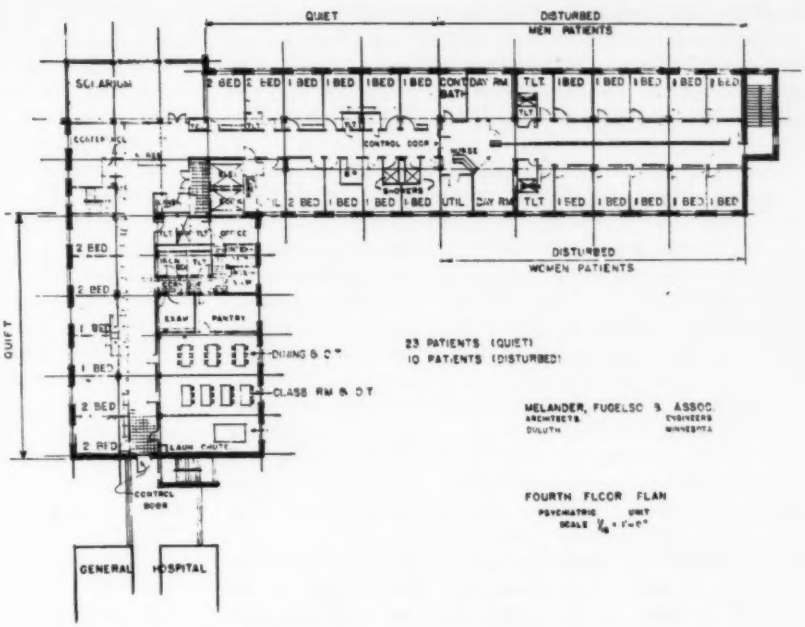
[1] *Patricia, Sister M.: Establishing a Psychiatric Department in a General Hospital, Hosp. Manag., 16:26-28 (Nov.) 1946.*

newer types of treatment evolved, they were adopted. The psychiatric unit thus became an excellent source of clinical teaching.

The community too began to feel the impact of the unit. The townspeople began to discard many of their fears and prejudices concerning mentally ill patients, and they became more appreciative and trusting of the care available for patients "at home." The hospital saw to it that beds near the unit were available for patients not requiring closed ward care. Thus, the unit had been solidly launched and was providing the high standard of care that a well-trained, qualified staff insures.

By 1946 the daily census of psychiatric patients in the hospital averaged about 50. Twelve years of experience enabled Dr. Gowan[1] to point out that, "In addition to providing treatment for those cases admitted to the hospital with a known mental disease, a special psychiatric department offers an additional service to every department of the hospital. From day to day in any general hospital there are many cases developing mental disturbances that either were not recognized at the time of entry or developed later as a complication of a medical, surgical, or obstetrical condition. . . . If for no other reason than practicability, general hospitals of the country must prepare to take care of psychiatric patients." Referring to St. Mary's unit, he noted that, "These patients are primarily acute cases requiring and receiving active psychiatric care. Cases of senility and other chronic organic psychiatric, or borderline mental cases requiring only custodial care are not placed in these beds if it can possibly be avoided. . . . In the present time of crowded hospital conditions there is always a waiting list."

Although not intentionally, St. Mary's had discovered: that—a hospital need not begin with the advantages of affiliation with a medical teaching center, large sums of money, or elaborate space and equipment; that—much valuable experience may be gained from a well-planned and staffed unit no matter what its size; and that—when revisions or additions become possible, the new and larger unit may profit in untold ways from this earlier work.



Architect's drawing of the unit, showing both open and closed areas.

TIME FOR A CHANGE

By 1954 the unit at St. Mary's was more than ready for its revisions and additions. The psychiatric department had long proved its worth to the hospital, and the administration realized the need for more suitable facilities. Accordingly, an entire floor was allocated for an expanded psychiatric unit.

The administrator, psychiatrists, psychiatric nurses, occupational and physical therapists, and the psychiatric social worker met regularly with architects to discuss the basic principles of a blueprint for the new unit. Hospital equipment, fittings, and construction were to be functional yet attractive, and there was to be ample floor space for recreational and diversional activities. Light and cheerful colors and materials were to be used whereever practicable; modern safety devices were to be mandatory; and a dining area and patients' laundry were to be included. In June 1956, after two years of planning and construction, the unit was opened and the patients moved in.

THE OPEN SECTION

The present unit is divided into two areas, one an open section of 24 beds, and the other a closed section of 10 beds. Each has its own nursing station, utility room, dayroom, and adequate bath and toilet facilities. The entire area is contained on an "L" of the fourth floor.

Upon stepping off one of the floor's two elevators, a person finds himself on the open section in a small waiting room adjoining the visitors' lobby. He then enters the spacious main lobby through electrically controlled doors. This room is located at the juncture of the two corridors of the "L." Here there is a nursing station, strategically situated so that the nurse has a view of both corridors and the dayroom. At the rear of the station there is a small conference room which is used by nursing staff, students, and psychiatrists. Nearby is a patients' telephone booth.

Opening off the lobby is the section's largest room—the dayroom. Patients have a view in two directions of Duluth's hills and a busy thoroughfare. The expansive

[1]*Gowan, L. R.: Psychiatric Care in Hospitals, J. Lancet, 66:389-392, (Nov.) 1946.*

window area promotes a light and airy atmosphere. Included in the comfortable surroundings are television and hi-fi sets, an aquarium, books, magazines, card tables, and a variety of games, all of which prompted one psychiatrist to note that it reminded him of a "small cozy inn."

The longer wing of the unit contains six private and four semiprivate rooms, two toilets, and a utility room. The shorter wing contains two private and four semiprivate rooms, two bath and toilet rooms, a patients' laundry, a floor kitchen, an examination room, and a multipurpose room. There are also two offices used by psychiatrists, clinical psychologists, and clinical instructors. An office for the psychiatric social worker is adjacent.

Some of the double rooms have connecting doors so that one nurse can take care of several insulin patients at one time, if necessary. Most of the private rooms have toilets and all rooms have lavatories. All rooms are similarly furnished and contain a bed with innerspring mattress, a bedside cabinet, an armchair, and a straight chair. There is a finger-tip call system to summon attendants. Wardrobes are recessed in the wall and can be locked. (Patients in the open ward are encouraged to wear street clothes.)

The floor kitchen is adjacent to the multipurpose room, which simplifies meal serving and the preparation of party snacks. Food is brought from the general hospital kitchen in electrically heated and refrigerated carts and is served from the unit kitchen. All patients who can possibly do so are encouraged to eat in the common dining room. Noon and evening meals are served family style except on more formal occasions. Frequently the patients, together with the nursing students and volunteers, arrange attractive formal dinners or smorgasbord suppers. The patients assist in all plans and preparations, make favors, and arrange floral and other decorations. Staff members and chaplains are often invited guests. There is candlelight and music during such meals, and an entertainment program afterward.

The large multipurpose room can be broken up into smaller units by extending one or both of two folding doors. The entire open area is used for dining, dancing, movies, and games. The smaller units can be readily converted for case conferences, committee meetings, group therapy, and family consultations. A piano, ping-pong table, movie screen, and record player are all available. A refrigerator is stocked with milk, juices, and fruit, which the patients are free to enjoy at any time unless they are receiving insulin treatments.

The medical examination room is completely outfitted with standard equipment for the use of consultants and psychiatrists. A patients' laundry, complete with modern facilities, is used by both men and women.

THE CLOSED SECTION

A door at the end of the corridor of the longer wing leads directly into the lobby of the closed section, which is considerably removed from the elevators and general traffic of the open section. Within this area, there is a nursing substation and utility room.

All rooms in this section are private. They are smaller than those in the open section, and the wide corridor is divided into two halls by a partition to segregate the men from the women. The partition has doors spaced at intervals so that nurses may pass quickly from one side to the other. There are five rooms on each side, and each section has its own day-room and toilet and bath facilities. The nurse in charge of the closed section functions under the direction of the head nurse in the open section. This guarantees unified responsibility and control, and facilitates the transferral of patients between the two sections. Patients in the closed section, when well enough to do so, join patients in the open section for recreation, occupational therapy, and dining. Otherwise, they are served meals in their respective dayrooms.

The services of clinical psychologists are used freely and the general hospital laboratories and X-ray facilities are available for studying patients. An encephalographic laboratory is also accessible to the psychiatrists for diagnostic studies.

THE THERAPEUTIC CLIMATE

Psychotherapy, drugs, and all forms of somatic therapy are prescribed according to the individual needs of the patients. (Our psychiatrists have never abandoned the use of insulin, believing that it has a valid place among other therapies.) Although six psychiatrists use the unit, and each has his preferred method of treatment, basic procedures are arrived at during staff conference.

Electroconvulsive, insulin-coma, and subshock insulin treatments are administered in the patients' rooms. The psychiatrists consider this to be less emotionally traumatic to the patient than being moved to a special section for treatment.

Cognizance is taken of the importance of the family in the etiology and treatment of mental illness, and psychotherapy is extended to all family members, whenever possible or necessary.

The occupational therapy department is on the floor below the psychiatric unit. Three registered therapists and their aides carry out treatment programs under specific prescription from the psychiatrist. Patients may spend two periods a day, five days a week in this department.

Although the psychiatrists are always in control of all therapy programs and procedures, all staff members and other personnel collaborate in endeavoring to create a therapeutic environment. The patient is the focus of all activities and services. He is accepted as he is, treated courteously, kindly, and with deep respect by all members of the hospital staff.

The chapel and the services of two chaplains are resources always appreciated by the patients. The chaplains are invited to all meetings and conferences on the ward and respond regularly, giving information pertinent to their field of interest.

Since many patients become ill through faulty environments and relationships, care is taken to make their hospitalization as productive as possible in terms of increased confidence in themselves and in other people.

Those who have been on the section the longest, or who were less ill to begin with, help the more regressed and depressed patients. The communication that takes place in this way has been recognized as definitely therapeutic. We value and depend upon the benefits which accrue to the patients through all environmental and relationship therapy.

EVERYONE IS A TEACHER AND A STUDENT

The psychiatric unit affords an excellent medium for education and clinical training. Although all our psychiatrists are in private practice and there are no fellows or residents in psychiatry, an ongoing educational and training program is maintained under psychiatric leadership. Through lectures, case conferences, and scientific departmental meetings, the proficiency of all ward personnel is advanced. Close association with psychiatrists in the day-by-day care of patients affords a learning experience par excellence for nurses, students, and others. Interns have an opportunity to observe, study, and treat mentally ill patients. Thus they gain greater facility in treating emotional disturbances whenever they encounter them. This is an important part of their general medical training.

The psychiatrists also devote a great deal of time to bringing greater psychiatric understanding to other doctors, interns, nurses, and paramedical personnel in other departments. Through consultations, ward rounds, case presentations at medical staff meetings, and lectures on the various aspects of mental and emotional illness, they increase awareness and appreciation of the close affinity of physical, organic, and emotional factors encountered in a high percentage of patients cared for in all sections of the hospital.

The chief psychiatric nurse and her assistant are responsible for the orientation of new personnel and for the continuing instruction of all staff members and students. Through conferences and individual case discussions, they impart basic knowledge, explain policies and procedures, prescribe correct attitudes, and demonstrate methods of approach and treatment.

Our psychiatric clinical instructors are on the faculty of the Department of Nursing, College of St. Scholastica, Duluth. They are in charge of the formal classroom education of students on this unit, and direct and supervise their clinical experience. The psychiatrists give class lectures covering specific areas of emotional illness such as etiology, behavior manifestations, treatment, and rehabilitation. The program proposes to help students toward their own maturation as well as to prepare them to meet the needs of their patients. They obtain a more complete concept of therapy for the "whole" patient when other physicians, as well as psychiatrists, are cooperating in the care and treatment of patients.

The psychiatrists present papers based on research data derived from patients' charts, at medical staff meetings of the general hospital and before other medical groups. Interns occasionally elect psychiatric patients for special study and report. Nursing students are given simple research assignments by the clinical instructors. They once made a study of alcoholic patients admitted to the unit over a period of years, which was a boon to the entire staff. Medical records library students have also prepared studies based on the histories of psychiatric patients.

Students and volunteers are especially great assets in the treatment program. Students bring youth, gaiety, humor, and human interest into the ward, and patients relate to them readily and happily. Volunteers keep intact the patients' interest in the outside world and give evidence of the community's concern and interest in them.

Volunteers have been an important part of the psychiatric unit family now for some ten years. They function under the direction of the psychiatric social worker. Depending on their interests and aptitudes they may choose an assignment involving a one-to-one relationship with a patient, or they may assist in planning and directing group activities. A close "working together" spirit exists between volunteers, nursing students, and patients. Clinical instructors insist that nursing students on the unit have some experience in the area of planned recreation, and they receive this as a regular assignment at some point of their stay on the ward. Volunteers are also able to give substantial support and direction to the students in this phase of their experience since they are aware of community resources and talent.

Another example of the unit's interstaff cooperation is the "coordinating committee," which is under the cochairmanship of the head nurse and her assistant, and includes nursing students, volunteers, clinical instructors, occupational therapists, and a social worker. This committee plans and regulates the calendar of activities and then correlates the efforts of the several groups involved, such as the patients, nurses, students, and volunteers.

ACTIVITIES: A JOINT EFFORT

A rich variety of activities is maintained, including singing, square dancing, folk dancing, ping-pong, shuffleboard, bowling, bingo, and movies. Occasionally, interested persons from the community teach hobby classes such as hat-making and bird-watching. In the summer, patients can enjoy baseball, croquet, horseshoe pitching, and gardening in the two outside recreation areas. Garden tables, umbrellas, and chairs entice patients outside to play cards, sew, visit, or read. Additional treats are outdoor suppers. When relatives and friends are visiting, they are invited to participate in the activities. Students and volunteers, as well as aides and orderlies, accompany patients on hikes, downtown trips, picnics, movies, and church. Occasionally volunteers invite patients to their homes for tea. Recently the volunteers asked if they could plan activities for discharged patients in their homes. To a limited degree they have done so. Through events such as these, patients can begin to appreciate the role they must play as citizens.

Because of the generosity of St. Mary's Hospital Auxiliary, patients and staff are now enjoying a piano, television, punching bag, and a variety of games. The Auxiliary also subscribes to two daily papers and several magazines for the patients, and rents movies for their pleasure.

In many ways the psychiatric unit reaches out into

the community. College and university classes tour the section and listen to panel discussions concerning mental illness, modern treatment processes, and community resources. Sociology classes and psychology majors, particularly those who are taking classes in group work, gain experience in directing activities for the patients. Other students do regular volunteer work. If they are casework students and wish to have direct contact with patients, special orientation and instruction classes are arranged for them. The Hospital Auxiliary has featured psychiatrists at a number of its meetings. Community organizations and societies of every sort call on psychiatrists to give talks to their members, and citizen mental health groups in Duluth have been stimulated in their work by the support, encouragement, and active help given by the psychiatrists.

The psychiatric clinical instructors are active in providing unusual opportunities for members of the faculties of local colleges, the nurses of the general hospital, and the staffs of local social work and mental health agencies to share in special offerings. As a typical project, the instructors rented the series of 13 films, "Understanding Human Behavior," which were produced by the Department of Psychiatry and the Department of Radio and Television Broadcasting of the University of Minnesota.

St. Mary's has found that it is possible for a general hospital to increase its value many times over by adding a psychiatric unit. This can be accomplished, even though the hospital is far removed from a medical school, if psychiatrists in private practice are interested and willing to devote their time; if the governing board and the administrator recognize the need for such a unit and are willing to lend full cooperation to make the necessary provisions for it; and if staff members are specially prepared and trained in this field so they can improve and direct the services of all personnel.

UNIT A BASIC DEPARTMENT

St. Mary's psychiatric unit has been operating continuously for 26 years. During this time 13,781 mentally ill patients have been treated. Many have been helped to recovery and renewed lives. All have had careful study and, if not kept in the hospital for treatment, have been assisted in making plans for continued care elsewhere. Medical patients in the general hospital have had the advantage of psychiatric consultation when needed. Staff and lay persons have benefited from the educational programs. Certainly no one would think that our hospital was functioning up to its full potential if the psychiatric unit were not one basic department. •

Have You Read?

LIVING IN A CIRCLE—A PROPOSAL FOR A RESIDENCE FOR DISTURBED CHILDREN—by Gladys A. Hillsman, R.N., and Paul D. Spreiregen. The September 1 issue of *Hospitals* presents the interesting plan of a nurse and an architect to make the institutional setting more beneficial to both children and staff. It is "based upon the circle, a symbol of warmth, closeness, and protection" and consists of two principal units, both round. "The major building, the 'home' looks inward, emphasizing security. Its large size and dominance and its 'community' emphasis are supplemented by the many small rooms around it, where the child may retreat for privacy without losing his feeling of 'belonging.' The school, in contrast to the inward-looking home, looks outward to the signs of nature in the nearby world." The plan also has the advantages of allowing better supervision of the patient at all times and promising an appreciable and welcome cut in staff "mileage."

FACTORS INFLUENCING THE INSTITUTIONALIZATION OF MENTALLY RETARDED INDIVIDUALS IN NEW YORK CITY—This is a study conducted by Gerhart Saenger, Ph.D., director of the Research Center of New York University's Graduate School of Public Administration and Social Service, under the auspices of the N. Y. State Inter-Departmental Health Resources Board. It was designed "to cast further light on the many faceted social-medical problem of retardation, with particular emphasis on clarifying the factors related to institutionalization and the complex interaction between these factors." Dr. Saenger presented the findings of this study at the Conference on Scientific Study of Mental Deficiency held in July in London, England. One of the significant findings of this two-year study is that parents who institutionalize their retarded child do not necessarily love him less or treat him with less affection than those who are able to keep him at home. But the degree of mental retardation, family income and ethnic background, family adequacy, and the adjustment of the retardate as measured in terms of the presence or absence of difficulties in the community were disclosed by the study as the major factors determining institutionalization.

HELPING THE DYING PATIENT AND HIS FAMILY—The subject of this booklet published by the National Association of Social Workers "has long been a concern of many professions." The papers presented here are the considered opinion of members of three professions: the ministry, psychiatry, and social work. Although the Rev. Robert C. Leslie, Ph.D., Charles W. Wahl, M.D., and Nathalie E. Kennedy, M.S.W., address themselves primarily to social workers, they find their way to all who come in contact with death. The 31-page booklet sells for 75¢ and can be obtained from the N.A.S.W., 95 Madison Ave., New York 16, N. Y.

Deadline for Family Care

By WANDA PARTRIDGE
Clinical Social Worker
Neuropsychiatric Hospital, VA Center
Los Angeles, California

BECAUSE MY FIRST GROUP THERAPY PROJECT to prepare patients for Family Care had proved successful and a source of information from patient to patient, the ward doctor asked me to start a second group—but this time with a difference. The purpose, preparation for Family Care, was to be the same, but this group was to have a three-month time limit. This was set at the suggestion of the chief of service, who also acts as consultant for the groups, and who thought it might help motivate the participating patients and act as a dynamic force in arousing and focusing anxiety on an imposed reality.

We selected ten patients for the group. All were schizophrenic with no history of alcoholism, overt homosexuality, or asocial sexual problems, such as child-molesting. All had irrevocably negative family situations, and some income to finance their Family Care placements. The other criteria for selection had to do with the patient's behavior, which was required to be predictable and not acutely psychotic; be such that he could communicate and relate with others and accept guidance and help; and be acceptable in thought and action to society.

Of the final group, one was 26 years old and the rest were from 36 to 50. All but the 26-year-old had been sick from 14 to 17 years. Five had been on one to five unsuccessful trial visits to family, and five had been continuously hospitalized from ten to fourteen years. For purposes of identification and continuity, we shall call them Anderson, Brown, East, Gomez, Harvey, Hernandez, Jones, Montoya, Riley, and Robinson.

At my request, the ward doctor talked with each patient about joining the group; outlined its purpose, time, and place of meeting; and made it clear that the patients were expected to attend.

The following are some of my observations. There is no attempt to describe in full what occurred—but rather a speculation on the effect of the time limit as reflected in the talk and behavior of the group.

GROUP SESSIONS

FIRST MEETING—December

All ten to group on time. As Brown enters room, says, "They've got the wrong person. I don't believe I belong here."

I reviewed time, place of meeting, purpose of group (to discuss the idea of going to Family Care) and stated firmly that all were expected to come. I ended saying, "The doctors and I expect that by the end of three months you will be ready for Family Care."

Group made no comment on this but began to ask general questions about Family Care program.

After about ten minutes, the conversation died and Montoya asked, "Did you say three months?" I nodded and Montoya turned to the calendar on the wall and said, "That makes it March 11—that's my birthday."

Several patients repeated "March 11." Brown giggled, made some funny gestures and said, "There's some mistake, I don't belong here."

Group returned to questions regarding Family Care.

SECOND MEETING

All present in group—on time.

More questions and conversation about Family Care homes, interspersed with frequent reference to calendar and asking, "Did you say three months—March 11?" There is considerable tension and getting up for matches, moving chairs. Brown giggles a lot—waves his arms and seems to be responding to voices.

Harvey talked delusionally and Robinson asked him what was the matter—"I haven't heard you talk that way in a long time." Harvey responded with, "Oh, yeah," and began to talk sense.

We ended with sort of a group "summing up" of what they knew about Family Care.

THIRD MEETING

Brown late to group. When he arrives—says, "Really, you know there's some mistake about this." Group laughs and tells him to sit down.

I opened meeting inquiring whether group would be interested in unaccompanied passes on Saturdays to the Domiciliary area in another part of the Center.

There was much griping about, "Why just Dom—why can't we go to Santa Monica?"

I held to limit of Dom—and suggested perhaps later Santa Monica when you seem up to it.

Griping and pushing on me continues until Riley said, "Look, this is December 30, let's not waste time arguing. I'll take Dom."

The rest agree—and talk about how to pick up pass, hours and rules for pass, need of extra money for Dom canteen purchases, and so on.

FOURTH MEETING—January

Passes to Dom had started. Jones and Hernandez didn't go—said they weren't "interested." Brown, Robinson, and East went—but only after much support and urging from charge nurse.

Group discussion focused on anxiety about "getting dressed up," going through gates, finding way around at Dom and getting back safely.

I note for myself, there are no questions, no discussion about specifics of Family Care. Interesting?

FIFTH MEETING

Jones and Hernandez "take a chance" and go to Dom for about an hour. They're pretty scared. Jones is chewing gum a mile a minute, tapping his foot—rolling his eyes. Hernandez is flipping and snapping his fingers. Brown giggles a lot.

Rest of group seem much more comfortable on pass—have surveyed the Dom area and enjoyed the canteen.

Again no discussion about Family Care per se. Discussion centers on what they saw and did at Dom. Some concern expressed about keeping track of time—fear of overstaying pass.

I note Gomez is unusually quiet in group, and on ward when he sees me around, pulls at his pants and makes suggestive sexual movements.

SIXTH MEETING

Jones and Hernandez didn't take pass to Dom—"were tired." Jones chewing gum like mad, rolling eyes, chain smoking. Hernandez sleeps through group. Brown acting silly.

Rest of group seem suddenly "old hands" at Dom passes—are familiar and comfortable with Dom area and say they have seen and done everything there is to do.

The calendar seems to become important again—much looking at it. Montoya says, "It's January 22—almost the end of the month. If we are going to have a chance to see what it is like outside before we go to Family Care, we had better start going to Santa Monica.

More reference to calendar—comments about "time going fast"—"less than two months left."

With permission of ward doctor I agree to passes to Santa Monica for those who feel up to it. Jones and Hernandez say they don't—loud and clear.

Discussion turns to rules for passes—when to be back, how to dress.

Questions about where to get bus—how to pay fare—where to eat. Riley says he knows about buses—looked into it on pass to Dom. He suggests they "go as a group—we can help each other." Group argues, with Montoya saying, "You guys are going to have to help me—I haven't been out of here in 14 years and I don't know my way around."

Group assures him they'll take care of him.

SEVENTH MEETING

Robinson, East, Brown, late to group. Jones and Hernandez didn't show up at all. Anderson soiled himself in group. Gomez on ward, "pulling pants." A pretty tense bunch (including the social worker, I might add).

Group on "high side," very animated, full of talk about pass to Santa Monica—what they saw and did. All had gone except Jones and Hernandez.

"Coffee costs 10¢." "You have to pay 10¢ to go to the latrine." "I ordered a top sirloin steak and I almost passed out when I got the bill—$4.52! Jeez $4.52."

East says he did "pass out"—as he tells it, rolls his eyes back, slumps in chair and pretends to be "out." I got quite concerned and asked in a worried way if pass was too much and East nods.

Group members laugh, and tell me not to worry. "He's just fooling you. He did just fine. There's nothing the matter with East—he's in real good shape."

Brown says he found a nice little restaurant on the pier—had a nice cup of tea and a piece of lemon pie. He then gets up, laughs in a silly way and acts as though he is responding to voices.

No questions about Family Care program.

EIGHTH MEETING—February

Brown, Robinson, East, Jones late to group. Hernandez didn't show.

As I walked in the room—group is gathered around the wall calendar talking in an angry way. They greet me with, "You're cheating us."

I am rather stunned—but manage to get out, "What do you mean?"

In a chorus I am told, "There's only 28 days in February—you're cheating us out of two days."

I agreed that the calendar was right and February had only 28 days. They talk about time passing so fast—count off the days to March 11. They seem pretty edgy—and really quite angry with me. Much pushing on me about, "Do you really mean we'll be ready March 11?"

I just let them sound off—nod once in a while in agreement. After about ten minutes of this, talk turns to what they did on pass.

Montoya went to a movie, lost track of time—got back 4½ hours late and scared silly—*"IT WAS DARK!"* he says.

All express concern for him and talk about need for watches.

Rest of group came back early. Much, much, much discussion of the world outside. "The trip sure is long." "Everything's expensive." "We're veterans, why can't we ride the buses and get in the movies free?"

There is a spontaneous expression of "we're scared—but we want our passes just the same."

NINTH MEETING

East, Robinson, Jones late to group.

More talk about Santa Monica, what they saw and did.

East and Robinson overstayed pass; got back at 12 midnight. They claimed they got lost—but finally admitted they just wanted to see what would happen if they were late.

They found out! The ward doctor picked up their privilege cards for three days and warned them if they broke rules again they would be grounded for two weeks.

Much discussion of rules: "Rules—rules—rules—everywhere you have to learn to live by them."

Brown announces proudly he went out again. "I had a delightful time on the pier. Had a nice cup of tea, ice cream and a piece of pie." He describes the boats—people fishing, what a lovely sunny day it was and says,—"You know I am rather surprised, I am really having a good time." He asks the group if they think he can make

it in Family Care. They express doubt and point out that he is still acting pretty crazy.

Brown says, "Oh yes,—I see what you mean."

TENTH MEETING

Robinson and East "in mourning." Brought back one-half pint of rum from pass—took it to the ward—got cups and served other patients.

This reported to doctor and—just like he said—they lost their privilege cards for two weeks.

They plead with me to intercede for them with the doctor. "You're our pal—you can fix it up." I refuse, saying this is between them and doctor. I am accused of being hard on them.

Group is critical of them and Harvey says, "Maybe they are trying to fix it so they can't go to Family Care."

Brown again tells of a pleasant day—he again asks group if they believe he can make it in Family Care and he gets the same answer, "Not if you act crazy the way you do around here."

I told Brown that I was curious about something and if I were to ask him a straightforward question, would he give me an honest answer. He said he would—so I said, "Well, this is the question—When you are enjoying yourself on your passes in Santa Monica, do you act crazy?"

Quite indignantly he replied, "Why of course not! People would look at me and think there was something wrong with me. Of course I don't—I act perfectly normal."

Group laughed and said it was about time he started acting normal around the hospital.

Anderson says he needs some new clothes—wonders if Riley and Montoya will help him "get into a store, next pass." They agree to help.

ELEVENTH MEETING

Robinson and East still without privilege cards—very remorseful. "We'll never, never break rules again. This has been tough—Gosh, this has been a long two weeks—but Saturday we can go on pass again."

Harvey comments, "They'll probably foul up again. I don't think they want to go to Family Care."

Jones and Hernandez went on first pass to Santa Monica—but don't want any more—"There's too much out there."

Anderson says he bought a new suit—has to go back to get it fitted. "It's better looking than what you can buy here at the hospital."

Brown has had another pleasant day on the pier with several cups of nice tea—pie—plus a full course shrimp dinner. "Really very nice," he says—and asks, "Miss Partridge, do you believe I can make it in Family Care?" I told him that I had hope that some day he could, but I didn't know whether the time was now, because it seemed to me he had a lot of things to settle with himself. He replied, "Yes, I see. You are very honest with me—but you do have hope for me?" I said I did.

TWELFTH MEETING—March

Jones and Hernandez don't go on pass. Others are widening their horizons—new restaurants, new foods—have found the tram to Venice, and Fun Zone at Ocean Park. No rules broken. A pretty comfortable bunch—act like "men-about-town."

All have been getting into stores and I see new cigarette lighters, tie clips, colorful shirts, etc.

We are back to the calendar again—"Only two more weeks and we can go to staff for Family Care."

There is a return, also, to the Family Care program—a sort of reviewing what they know about it—how it works and much stress on; "We still belong to the hospital." To me, they seem pretty comfortable.

Brown announces to the group that he believes he can make it in Family Care.

THIRTEENTH MEETING

Pretty comfortable bunch—the eight are old hands with their passes. No rules broken. Montoya has a new watch "to help keep track of time in Family Care."

"Well, this is the day, March 11."

"When can we leave for Family Care?"

"Boy, this sure has been a lot of hard work, this group."

"You sure worked us hard, Miss Partridge."

"This has been rough—the toughest three months that I have had in my 14 years of hospitalization—but it paid off."

Brown says he is ready to try—really try, and "You know I believe I can make it."

Jones and Hernandez announce they just can't do it—not yet anyway.

As planned, group sessions stopped on March 11. Each group member was seen by the ward doctor and the chief of service in an evaluation staff. Of the ten patients, seven were considered improved, and ready for placement in Family Care Homes. Three patients—Jones, Hernandez, and Gomez—were in need of continued hospitalization.

Comments by Miss Dorthea M. Lane, Assistant Chief, Social Work Service

Miss Partridge's group therapy experiment was constructive because the three-month time limit focused the anxiety of patients on the reality of leaving the hospital. The patients' energy went into "mustering their forces" to leave. I believe that Miss Partridge's open and highly supportive approach to the patients was a factor in their movement. Her confidence in them and their feeling of comfort in being with her are reflected in the recordings. The contrast between this group and the long-term group was the fact that current problems were all the short-time group had time for, whereas the other group permitted patients to review and perseverate on the past. The time-limited goal seemed to make the difference.

It must be remembered that this group therapy took place in a ward where the social worker has been consistently available to patients and has helped plan and stimulate development of the total ward program. There is a genuine meshing of patients' needs as expressed in this group, and implementation of them by ward personnel. This is seen in purchase of new clothing, allowances, and passes. Unless cooperation of other ward personnel existed, the progress of patients would be impeded.

All personnel are involved in a patient's leaving this ward for an outside placement. Their observations on various phases of his hospital life are used in evaluation of his readiness. Although this is a short-term group, the ward activity program, selection process, and work with existing relatives are carried on before and after the group therapy sessions, so that the total process of preparation (of which this short-term group therapy is the climax) is about one year in length. Considering the length of hospitalization and chronicity of illness of these patients, and their repeated failures to live with their own families, this is good movement. •

Historical Highlights

By THADDEUS P. KRUSH, M.D.

PINEL AND POUSSIN

THE OTHER DAY while browsing through D. D. Davis' translation of Philippe Pinel's *Treatise on Insanity*, the thought occurred to me—how was it possible for Pinel to keep the chains off, once he had removed them? Even the newest resident on the ward is aware that any change in established routine is usually accomplished only with tedious delay and difficulty. Were the attitudes prevalent in revolutionary times the fertile soil on which a new idea might grow? That this was not so is attested by the fact that Pinel was investigated by the Revolutionary Tribunal as being subversive, while his own notes commented upon the excesses of the rank and file toward the patients.

The key (how appropriate it was to unlock an idea in a mental hospital) to the question is found on page 9 of the *Treatise*. "For these serious inconveniences [revolutionary distrubances], I found ample amends in the zeal, the humanity, and intelligence of the keeper [Monsieur Poussin]; a man of great experience in the management of the insane, and every way calculated to maintain order in the hospital. The advantages which I derived from this circumstance will stamp a greater value on my observations in the present treatise, than any attempts to discover or establish new remedies."

Again on pages 53-54 he states: "So destitute of accommodations, we found it impossible to class our patients according to variety and degree of their respective maladies. On the other hand, the gentleman, to whom was committed the chief management of the hospital, exercised towards all that were placed under his protection, the vigilance of a kind and affectionate parent. Accustomed to reflect, and possessed of great experience, he was not deficient either in the knowledge or execution of the duties of his office. He never lost sight of the principles of a most genuine philanthropy. He paid great attention to the diet of the house and left no opportunity for murmur or discontent on the part of the most fastidious. He exercised a strict discipline over the conduct of the domestics, and punished, with severity, every instance of ill treatment, and every act of violence, of which they were guilty towards those whom it was merely their duty to serve. He was both esteemed and feared by every maniac; for he was mild and at the same time inflexibly firm. In a word he was a master of every branch of his art, from its simplest to its most complicated principles. Thus was I introduced to a man, whose friendship was an invaluable acquisition to me.

"Our acquaintance nurtured into the closest intimacy. Our duties and inclinations concurred in the same object. Our conversation, which was almost exclusively professional, contributed to our mutual improvement with those advantages. I devoted a great part of my time in examining for myself the various and numerous affectations of the human mind in a state of disease."

Pinel has here accredited the staff charged with attending the patients' needs with the vital role they play in the daily life of patients. Without an inquiring humane attitude on the part of all attenders the ferruginous fetters are merely exchanged for human fetters.

The moral to this story is that good medicine cannot be practiced without good attendants—*Merci beaucoup, Monsieur Poussin!*

The Program Described in this Paper Received the 1960 A.P.A. Mental Hospital Service Achievement Award.

WIDENING THE TREATMENT FIELD

By STEVE PRATT, Ph.D., *Chief Psychologist*
PAUL L. REED, M.P.S., *Personnel Officer*
and RALPH C. ARNOLD, B.S., *Public Relations Officer*
Larned State Hospital, Kansas

ARE MENTAL HOSPITALS "obsolete—inherently pathogenic —freaks of history"? Before jumping aboard the *avant-garde* bandwagon bent on "blowing them up" we need to explore their undeveloped therapeutic potential as treatment facilities. The Community-Hospital Relationship Committee may provide one way for taking this long overdue new look.

Though admittedly at a snail's pace, mental hospitals are in a national process of undergoing a transition, if not a radical transformation, from being predominantly custodial to becoming treatment-oriented facilities. Major progressive thinking stresses as crucial the need to "de-ice" and "de-isolate" the mental hospital, in order to facilitate communication and interaction between the mutually exclusive hospital and town.

We would like to define the "treatment-field" in a wider sense than the purely clinical, i.e. as involving sets of relationships within the hospital-as-a-community, and between this hospital and the town; or more explicitly, as involving interpersonal relationships within and between the town, patient, and staff communities.

Here the present and potential role of a Community-Hospital Relationship Committee becomes evident. Such a group, even during its initiation, can start the ball rolling toward the long overdue reintegration of the isolated hospital and the apathetic town—a reintegration that may prove to be a necessary precondition for the custodial-to-treatment transformation of mental hospitals.

As a case in point, we will briefly indicate a few representative events associated with the recent organization of the Larned Community-Hospital Relationship Committee, involving this typical midwestern town and its adjacent large (1300-bed, 700-staff) state mental hospital.

The psychology department of the hospital had recently completed and released to the press part of a research project concerned with the attitudes of the town-community toward the hospital-community. Local and state news media editorialized at length about the "negative community attitudes" toward the hospital, which this release indicated. As a result, the superintendent, James T. Naramore, M.D., appointed a hospital staff committee on hospital-town relationships, and, quite independently, the Larned Chamber of Commerce created a hospital-relations committee, composed of civically active townspeople.

As a first step, the hospital committee drew up a detailed statement of purpose and set up a regular meeting schedule. (This group represented all hospital employees, since its members were chosen from personnel, public relations, clinical, and business services.) The committee then held a meeting with fifty officers of community organizations (representing a combined membership of several hundred) to discuss town attitudes and relationships with the hospital. Participating organizations included Lions; Kiwanis; Rotary; City and County Teachers; Chamber and Junior Chamber of Commerce; Ministerial Alliance; Farm Bureau; American Legion; VFW and its Auxiliary; the Larned daily paper, *Tiller and Toiler;* Business and Professional Women; and County Medical, Bar, and Nurses' Associations.

The hospital committee, as a next step, held a series of discussion meetings for the entire staff. Employees expressed their own ideas about hospital-town relationships, their importance, and how they could be improved. This type of mobilization with total staff participation was a new phenomenon. Staff members raised questions about

communication problems. The majority felt they weren't kept adequately informed, noting that their "main source of information is from rumors—more often wrong than right." Other eye-opening questions associated with community-hospital relationships involved morale and role status (stigma versus prestige).

Only then was it discovered that the original release, indicating negative attitudes, had included some erroneous findings, because of a coding error! The hospital promptly issued a correction, which was followed by another round of gratuitous publicity. Unexpectedly, however, far from arousing hostility in the community, the acknowledgment of the error had the reverse effect of "humanizing" the hospital in the eyes of the public. The community was eager for joint action to break down newly recognized but long-standing barriers between the hospital and the town.

Finally, after operating independently for some time, the community and hospital committees formally merged into the joint "Community-Hospital Relationship Committee." They held breakfast meetings alternately in town and at the hospital cafeteria. They planned future activities involving town participation in hospital projects and vice versa—henceforth to be set up as joint endeavors.

Community representatives suggested that the program for the hospital's annual civic dinner this year have the theme: "Community-Hospital Relationships." The suggestion was accepted and some three hundred persons attended from community organizations. Townspeople played a major part in the serious and satirical program. A local architect acted as master of ceremonies, and a combined hospital-community panel led a lively debate on the economic, social, political, and clinical aspects of community-hospital relationships.

In a return gesture, the civic clubs invited hospital staff members to their meetings in town to discuss the hospital treatment program. Full sessions were devoted to these discussions, with opportunity for free exchange of opinion. Questions and replies concerned misconceptions about mental illness, as well as misunderstandings about the hospital, its staff, and its treatment program. Specific discussions included electric shock, "miracle" drugs, prison versus country-club stereotypes, sex criminals, and many other topics. These meetings also provided ample opportunity to openly admit shortcomings and to increase understanding of limitations as well as to explore suggestions for bringing the hospital and the town closer together.

Both staff and townspeople raised the point that it is important in carrying on community-hospital relations to have better informed employees and a curtailment of sensationalism and rumor-spreading. With this in mind a daily information bulletin was initiated for distribution to every hospital employee. The *Daily Flash* caught on immediately with fresh coverage of such things as hospital events, personal items, and news. This has filled a long-felt need, providing a spring-board for communication, and facts rather than rumors for coffee-break gossip.

The Mental Health Week Committee planned this year's observance around community-hospital relationships. For the first time townspeople themselves played a central role in the joint MHW program. They produced a full length play dramatizing the overwhelming problems of rejection, prejudice, and insecurity faced by a discharged mental patient attempting to return to a family and job. It was a smash hit.

In another move to bring the hospital and town closer together, the Larned Chamber of Commerce elected the chairman of the Community-Hospital Relationship Committee (who is also the hospital's personnel officer) to its Board of Directors for a three-year term.

By this time long-standing barriers between town and hospital were also being penetrated by professional groups. For instance, arrangements were made for three town physicians to work at the hospital on a regular weekly schedule. The volunteer program began to take on new significance. Volunteers working with the help of patients and staff put on the best and largest Christmas program in the hospital's history. The project received wide publicity, the number of volunteer applicants rose sharply, and their activities continued to expand.

BIG BUSINESS

An editorial in the local newspaper lauded the merits of the hospital, calling it "Larned's biggest industry." It called for more volunteer participation in the Mental Health Week program, and backed the proposed salary increase for hospital employees. The community representatives of the Community-Hospital Relationship Committee, on their own initiative, involved the Larned Chamber of Commerce and other town groups in initiating civic action on behalf of "their" mental hospital. They prepared two resolutions which went to various state-government agencies and departments requesting a hospital post office sub-station, and they also pointed out the critical need for increased hospital salaries! Within four months the State Legislature acted on both suggestions, and employees have since received two rounds of salary increases. In his letter to the director of Kansas institutions, J. T. Naramore, M.D., the superintendent, most aptly described the work of these community organizations as, "nationally, historically unprecedented events."

Though the Community-Hospital Relationship Committee has made noteworthy gains, it has scarcely scratched the surface of possibilities for wider "treatment-field" participation of patient, town, and staff communities. For instance, does every member of these three communities, at some time, play an active role in relation to the treatment program? What imaginative new roles could be tried out and evaluated? Where are the patient-representatives on the committee, and what about other potential groups—farm, youth, teachers, clergymen, volunteers? It is quite possible that such reintegration may constitute the *sine qua non* for the custodial-to-treatment transformation that everyone talks about today.

Finally, to keep our feet firmly on the ground shouldn't we have the temerity to occasionally confront ourselves with the embarrassing question: Why is it that our mental hospitals, ostensibly staffed with experts in human relations, sometimes appear to have the poorest internal as well as the poorest public relations? •

The Twelfth Mental Hospital Institute

OCTOBER 17-20, 1960
HOTEL UTAH, SALT LAKE CITY

THE 462 PARTICIPANTS at the 12th Mental Hospital Institute held from October 17 through 20 in Salt Lake City, Utah, were honored by the presence of two Governors from the Intermountain states. The Honorable Milward Simpson, former Governor of Wyoming, and Mrs. Simpson, attended the Annual Dinner, and The Honorable George Clyde, Governor of Utah, took part in the psychiatric-legislative panel presentation held on October 19, the last day of the Institute. Governor Simpson, who is Chairman of the Western Council of Mental Health Training and Research, attended that organization's Annual Dinner on Wednesday evening, and visited the group and plenary sessions of the Institute itself.

The annual A.P.A. Mental Hospital Service Achievement Award and Honorable Mention Certificates (See Pages 25, 26, 30, 31, 32 for full details) were presented by Mathew Ross, M.D., the Medical Director of the A.P.A. W. N. Wilks, M.D., head of the outpatient department of Larned State Hospital, Kansas, accepted the Award on behalf of the hospital, in the absence of the superintendent, J. T. Naramore, M.D. Honorable Mention certificates were accepted for the Clarinda Mental Health Institute of Iowa by L. B. Garcia, M.D., the clinical director and for the New Jersey State Hospital at Marlboro by the superintendent, J. Berkeley Gordon, M.D.

A new presentation ceremony took place this year, when Robert S. Garber, M.D., of New Jersey, Chairman of the A.P.A.–S.K.F. Remotivation Project, presented Remotivation Pins to three psychiatric technicians from the Colorado State Hospital, Pueblo—Mr. Ted Low, Mrs. Josie Elliot, and Mrs. Margaret Lawson—and one to Miss Beulah Gardner, R.N., who is the director of nursing service at the South Carolina State Hospital at Columbia. These four people represented 3,000 other psychiatric aides and nurses throughout the country who have completed the Remotivation course and are actively working in such programs.

The Institute Program Committee, under the Chairmanship of William S. Hall, M.D., of South Carolina, is now in the process of evaluating the workshop groups and the plenary summations for the benefit of next year's Program Committee. Other members of Dr. Hall's committee were James E. Gilbert, M.D., South Dakota, Alfred Stanton, M. D., Massachusetts, Jack Lambert, M.D., New York, and Mr. J. C. Hodges, Michigan. Dr. Stanton succeeds Dr. Hall as Program Chairman and the President of the A.P.A. has appointed John Blasko, M.D., of Washington, D. C. and Mr. Joseph Greco of Missouri to be the two new members.

Because of illness in his family, Frank Fremont-Smith, M.D., was unfortunately unable to give his scheduled talk on World Mental Health Year. There was considerable interest in the Academic Lecture on the impending population explosion by Charles Westoff, Ph.D., of New York University and the Office of Population Research, Princeton, N. J. Printed copies of the lecture were distributed to those who attended.

A prominent feature of this year's Institute was the program of scientific and commercial exhibits. Although this is only the second year that the Institute has been open to commercial exhibitors, more than twice as many registered and displayed as in 1959. The "New Products" page in the December issue of MENTAL HOSPITALS will be devoted to a discussion of the products shown.

None of the papers given at the Institute, with the exception of the Academic Lecture, are available at the present time. They will be published, however, in the Proceedings Issue of MENTAL HOSPITALS in February 1961.

DISTRIBUTION OF INSTITUTE ATTENDANCE

Registration—enough said! !

FOCUSING ON The 12th Mental Hospital Institute

For the benefit of those who could not attend the 12th Mental Hospital Institute in Salt Lake City, MENTAL HOSPITALS is pleased to present some of the meeting's brighter moments as they were captured by a local professional photographer, Hal Rumel.

MATHEW ROSS, M.D.

JACK R. EWALT, M.D.

DANA FARNSWORTH, M.D.

A. B. STOKES, M.D.

On Tuesday, October 18, the Institute began when Mathew Ross, M.D., Medical Director of the A.P.A., introduced the keynote speaker, Jack Ewalt, M.D., of Boston, Mass., whose address covered the main theme of the Institute, "Needs of the Mentally Ill: Types of Effective Action Between the Community and its Hospital Facilities." Dana Farnsworth, M.D., also of Boston, followed with an outline of Tuesday's subtopic for discussion, "The Emotionally Disturbed Patient: Hospital and Community Collaboration in Providing Appropriate Treatment."

On Wednesday A. B. Stokes, M.D. of Toronto, Ont., outlined the second subtopic ". . . Hospital and Community Collaboration in Providing Aftercare."

On Tuesday and Wednesday, after hearing outlines for discussion in plenary session, the Institute participants gathered into 17 pre-assigned groups (7 groups consisting of about 40 members each, and 10 groups of 15 members) to consider problems, pertinent to the main theme, of one of seven influential "Communities." Above: T. J. Boag, M.D., of Montreal, Que., discussion leader in one of the larger groups explains that their specific concern should be with the "Patient Community."

In one of the small groups, David J. Vail, M.D., of St. Paul, Minn., poses a question to participants about the influence of their specific subject, "Professional Bodies," on hospital-community collaboration in treatment and aftercare.

AT THE ANNUAL DINNER

ACHIEVEMENT AWARDS:

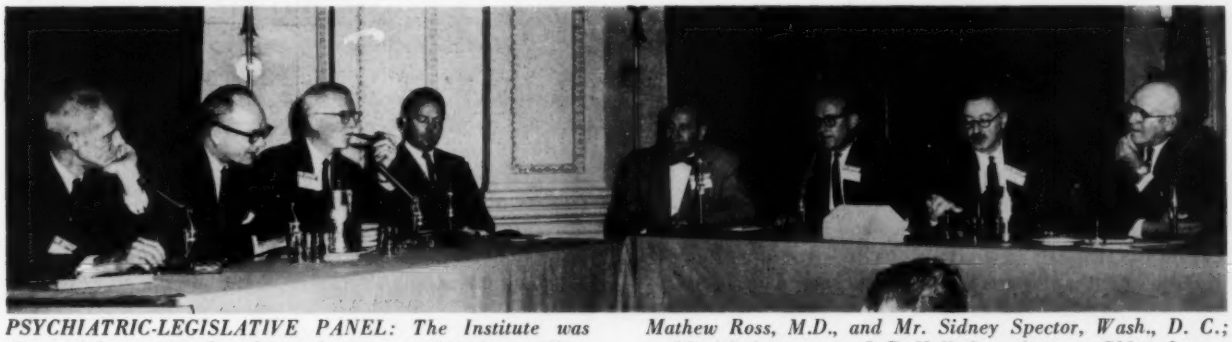
Mathew Ross, M.D., extends congratulations to the winners in the Twelfth Annual A.P.A. Mental Hospital Service Achievement Award Contest. From Left: J. Berkeley Gordon, M.D., who accepted an Honorable Mention Certificate for New Jersey State Hospital at Marlboro; Mathew Ross, M.D.; W. N. Wilks, M.D., recipient of the Silver Plaque for Larned State Hospital, Kansas; and L. B. Garcia, M.D., who accepted an Honorable Mention Certificate for the Clarinda Mental Health Institute, Iowa.

A prominent feature of this year's Institute were the exhibits. At left: Mathew Ross, M.D., admires the Nebraska Psychiatric Institute's display of how a new legal film, "The Appraisal of Competency," was animated with MENTAL HOSPITALS' *own Dr. Whatsisname. Explaining the finer points of cartooning are Barbara Brown and Thaddeus Krush, M.D., of the N.P.I. Staff. At right: participants visit the commercial exhibits during a break between Institute sessions.*

DISTINGUISHED VISITOR: Mathew Ross, M.D., welcomes former Governor and Mrs. Milward Simpson of Wyoming to the Institute. Governor Simpson is Chairman of the Western Council of Mental Health Training and Research.

SIMULTANEOUS SESSIONS: In one of the nine simultaneous sessions held Wednesday afternoon on various subjects, W. P. Hurder, M.D., Atlanta, Ga., addresses his group on "Organization for Research in Mental Health Facilities: The Experience of the 16 Southern States."

THE ACADEMIC LECTURE: On Thursday, Charles Westoff, Ph.D., Consultant to the Office of Population Research, Princeton University, N. J., speaks on the population explosion in his talk, "The Demographic Variable."



PSYCHIATRIC-LEGISLATIVE PANEL: The Institute was climaxed by a spirited exchange between psychiatric panelists, (from left) Paul V. Lemkau, M.D., Md.; Hayden Donahue, M.D., Ark.; Walter E. Barton, M.D., A.P.A. Pres.-Elect, Mass.; Mathew Ross, M.D., and Mr. Sidney Spector, Wash., D. C.; and legislative experts, J. R. Hall, State Senator, Okla.; Jerome Robinson, State Rep., Md.; and George D. Clyde, Governor of Utah.

PRESIDENTIAL ADDRESS: R. H. Felix, M.D., president of the American Psychiatric Association speaks on, "The Hospital and the Community."

Robert S. Garber, M.D., Chairman of the A.P.A.-S.K.F. Remotivation Project presents Remotivation Pins to (from left) Beulah L. Gardner, R.N., Director of Nursing Services, South Carolina State Hospital, and Margaret Lawson, Josie Elliot, and Ted Low, psychiatric technicians at Colorado State Hospital.

The Program Described in this Paper Received Honorable Mention in the 1960 A.P.A. Mental Hospital Service Achievement Award Contest.

THE CLARINDA PLAN: An Ecological Approach to Hospital Organization

By LEONARDO B. GARCIA, M.D.
Clinical Director,
Mental Health Institute, Clarinda, Iowa

SUPERINTENDENTS OF "INSANE ASYLUMS" in the middle of the last century attempted to keep their hospital populations to a maximum of 250 patients, so that they could become personally acquainted with each individual. "The Clarinda Plan," whereby patients are distributed throughout the hospital on an ecological basis, according to the geographical areas and sociocultural units where they lived prior to hospitalization, or to which they intend to return on discharge, has been able to re-establish this ideal to some extent.

Since the Institute serves 25 counties in southwest Iowa, we divided it into six county units, each unit occupying a group of contiguous wards. The capacity of each unit varies from 100 to 350 patients, and each serves from one to seven counties. Each unit is staffed by a "county team," headed by a psychiatrist, and including all the different hospital disciplines. The hospital superintendent, Karl A. Catlin, M.D., the clinical director, and the director of nurses act in an advisory capacity, but refrain from setting policies which might hamper the independent and autonomous operation of each unit. Thus no two units function alike, nor are they expected to do so. Instead, each develops its own approach to its catchment area, so that a maximum degree of integration and genuine symbiosis can exist in keeping with the specific features of the community it serves. The only exceptions to the county units are the general hospital, the alcoholic unit, and the research unit.

All physically incapacitated patients, either medical or surgical cases, go first to the general hospital. They remain, however, the psychiatric responsibility of their own county team members who visit them regularly.

The planning and implementation of the reorganization was relatively smooth. The first transfer of 150 patients to their new unit early in the fall of 1959 was considered as a pilot project, and the patient population was not apprised of the purpose. This resulted in a considerable amount of potentially dangerous free-floating anxiety. By the middle of November 1959 we stopped all movement of patients, and planned the final move carefully during the next two months. On a target date, January 16, 1960, the remaining population of over 800 patients were moved into their appropriate new units. The patients themselves had been told of the transfer and the reasons for it. Without their wholehearted cooperation, the completion of the move within four hours would not have been possible.

Team members are currently in the process of moving their offices to their respective areas, and planning decentralization of clerical help.

THE PLAN AND THE HOSPITAL

The main virtue of the new structure is that each "county team" enjoys the maximum of autonomy within its own unit. Nobody has any additional assignment. If a social worker, for instance, should resign, no social worker would be transferred from another unit; the remaining members of the team would carry on until a new worker could be appointed. Each county unit is developing its own approach to its corresponding geographical area. New staff will be recruited to fit the scheme, rather than trying to fit the organization to new staff.

Men and women patients occupy the same units. In two units, the architecture of the buildings (each with a capacity of 150 beds) has permitted mixing the sexes, except for dormitory areas and toilet facilities. Dayrooms, shops, and recreation facilities are used by both men and women. The rest of the hospital does not provide such an ideal arrangement, but in other units, wards have been staggered so that a women's ward is always immediately contiguous to a men's, the door between usually being open at all times. As most of the hospital is "open," patient traffic to and from living areas is unhampered. Patients without grounds privileges are encouraged to leave their wards, under inconspicuous supervision, to attend mixed activities. Enough

space is provided throughout the hospital for those who require privacy.

"Intensive treatment," "continuous treatment," "geriatric," and other conventional services have been discontinued. We believe that such classifications would destroy the ecological concept, and although it is early to draw any conclusions, the often-predicted problems resulting from "mixing" patients have failed to develop. We find the flexibility of not being bound by "clinical" or "management" classifications is giving excellent results, because patients can be placed according to more natural human groupings. A rather dramatic illustration is the case of a married couple in the hospital—both over sixty—who, since admission over a year ago, had been separated except for a few hours each day, because they belonged to different sexual, diagnostic, and behavioral categories. Under the new plan, they have been given a room with a double bed (perhaps the first in the history of institutional psychiatry in the U. S.). Both have shown a tremendous degree of improvement without any further "therapy," and discharge is becoming a real possibility.

Each unit has ancillary services, but since we do not have enough professional activity workers, "patients' activity councils" have been created. Patients and aides are assigned to work in various existing activity programs until they are familiar enough with the necessary techniques to fill in for our incomplete staff.

This is only one example of patients' assuming responsibilities. One selected group is given prescriptions to take to the hospital pharmacy, and they are responsible for giving themselves their own medications for a week or more. Patients are encouraged to help other patients—the emphasis being on having them do the sort of things they might do in the community.

The outpatient department, which under the old system had two psychiatrists assigned to it, has been integrated into the ecological scheme. All physicians and other workers are now engaged in outpatient work, on the basis of the patient's county of origin. No centrally located quarters are provided for the clinic. Instead, patients are seen by physicians in their offices in the corresponding county unit. Any individual in need of outpatient treatment will be handled by the "county psychiatrist" and "county team" covering his geographical area. If he then needs hospitalization, the same professional team will handle him throughout his inpatient period. Follow-up on discharge will be provided by the same team. Therefore, continuity between the professional team and the patients will not be broken.

THE PLAN AND THE COMMUNITY

Every mental hospital is unique in its own social and cultural patterns. It is the community which should provide the atmosphere in which patients are treated, and this community-conditioned atmosphere may well be the most important single factor in the efficacy of treatment. As Dr. Rees[1] has pointed out, the community is not yet ready to share fully in a mental health program whereby long-term treatment and social readjustment can take place entirely within the family circle. But a psychiatric team with a definite catchment area based in the community rather than in the mental hospital itself, and having responsibility for the treatment of all the mentally ill people in the area, would develop a better conception of the mental health problem as a whole.

THE PLAN AND THE FUTURE

We hope that, under the new plan, the Institute is becoming assimilated into the community. Boundaries are being erased, and reciprocal exchange is not only being facilitated, but also made unavoidable. The Institute, we hope, will become just one of many available community resources, so that hospitalization will come to be considered as an incidental and transitory stage in the over-all approach to treatment. The emphasis is gradually being shifted to provide the community with an over-all psychiatric service which will enable problems to be detected early and an evaluation to be made of the family's suitability to manage the patient at home. Thus the Institute will become mainly a center for the treatment of those difficult problems which are not manageable in the community. But, if the community can be enabled to cope tolerantly with some varieties of aberrant behavior, then chronic schizophrenia and senile psychosis can, and should in most instances, be managed in the community with a suitable amount of psychiatric supervision.

Another hope is that, by providing each community with its own mental hospital, an estimate of hospital costs on the basis of ecological structure can be made. Thus, instead of each county's paying a state average, it would pay whatever are the real costs of caring for its own patients. The percentage of geriatric patients, for instance, varies significantly in each area we serve. Some county areas send us mostly elderly people, others mostly alcoholics, and still others a larger proportion of children and adolescents. Costs of caring for these categories of patients vary considerably.

As time goes on, we envisage the possibility of learning more and more about the sociocultural structures of the counties we serve, and ultimately, perhaps, helping to uncover new causative factors of some types of mental illness. Human ecology is destined to play an important role in psychiatry.

Under our new plan, the psychiatric nurse will play an increasingly important role, especially in helping relatives to deal with difficult patients, and in assisting the family doctor to carry out more efficient office and home treatment. The closing of our "disturbed wards" made available a number of nursing personnel who had become skilled in the handling of agitated or aggressive patients. These professionals are now available to the communities we serve, so when specific instances of unmanageable behavior occur, they can assist in bringing the patient into the hospital without resort to mechanical restraint, thus minimizing the trauma of the patient's initial contact with the Institute. •

[1] *Rees, John R.: World Health Organization Tech. Rep., Series, No. 73, 1953.*

The Program Described in this Paper Received Honorable Mention in the 1960 A.P.A. Mental Hospital Service Achievement Award Contest.

A "Residency" Program for Nursing Personnel

By J. BERKELEY GORDON, M.D.
Medical Director
New Jersey State Hospital at Marlboro

ONE SEPTEMBER DAY in 1956, four men and a woman began training as professional nurses at Monmouth Memorial Hospital (now the Monmouth Medical Center). These five people were different from the other nursing students because they were graduate psychiatric technicians from nearby Marlboro State Hospital; the state had agreed to underwrite their full tuition of $500 a year, to pay all of their salary for only twenty hours of work each week, and to continue their Civil Service benefits. How did this come about?

In the first place, their hospital administration was convinced of its responsibility to guide qualified and interested persons into the field of professional nursing, and at the same time help alleviate its own chronic shortage of nurses. Further, it had long desired to promote or reward some of the hospital's outstanding psychiatric technicians. A nursing scholarship program, though of necessity a long-range plan, seemed an excellent step in both of these directions.

With the medical director and the personnel director looking into the possibilities of scholarships, and the director of nurses heading a screening and selection committee, a program was gradually developed which met with the approval of V. Terrell Davis, M.D., director of the state's Division of Mental Health and Hospitals. The director of the Monmouth Memorial Hospital School of Nursing addressed the psychiatric technicians at Marlboro, left application forms with the hospital's director of nurses, and the scholarship program was under way.

A psychiatric technician wishing to apply for entrance to the nursing school under the scholarship plan has a preliminary appointment with the director of nurses, and then makes formal application for acceptance by the nursing school and the scholarship committee. All applicants are required to take the regular pre-entrance examinations for the nursing school. Subsequent approval by the scholarship committee is based on the applicant's employment records and his demonstrated desire and ability to complete such a program. Initially, no more than five psychiatric technicians were accepted into the program each fall. This has since been revised to include qualified institutional attendants and institutional charge attendants.

As stated above, the employee-student remains on the state hospital payroll at full salary, although working only half time—twenty hours a week. His schedule is flexible, to avoid conflict with the nursing school schedule, but his duties and responsibilities are unchanged, and he works in the same capacity in which he was employed before entering the school. He is entitled to full Civil Service benefits during the two years, and the state pays his tuition of $500 a year. The student assumes the costs of his own books and uniforms and, in return for his scholarship, promises to work for at least two years as a staff nurse at Marlboro after graduation.

Some of the required subjects, (e.g., college English, social psychology, chemistry for nurses, microbiology, anatomy and physiology, rise of Western civilization or problems in Western civilization, and one elective) are taught at Monmouth College, just a few blocks from the nursing school. Thus it is possible for the student to acquire thirty-four college credits—more than half the requirement for the Associate of Arts degree. Students who have already had some of the required subjects may substitute other courses and gain further credits toward a Bachelors degree. Since the course is only a two-year one, the student can earn the salary of a graduate nurse one year sooner than if he had entered a conventional three-year course.

We at Marlboro look at our nursing scholarship program and like what we see. The significant fact is not that the scholarships have been given, but rather that none of the recipients would have been able to attend nursing school had any one feature of the program been omitted. Employee morale has improved with the opportunity to break out of the unskilled nursing level to professional status, and the program has afforded financial rewards and public recognition to those who have completed it. The hospital, too, has benefited by improved status and recognition in the community through the general hospital training school and the high academic and ethical standing of our student representatives.

Most important, in the long run we will be able to staff our hospitals with more competent and well-trained people, and will simultaneously raise our standards of patient care and treatment. •

Legislating Against Disaster

By W. C. BRINEGAR, M.D.
Superintendent
Mental Health Institute
Cherokee, Iowa

IN THE EVENT OF NUCLEAR WAR, with numerous casualties among the civilian population, state psychiatric hospitals and those operated by the Veterans Administration, counties, and other agencies are a potential source of great help to the sick and wounded. In contrast to most large general hospitals, the majority of psychiatric hospitals are situated in areas not likely to be destroyed by nuclear attack, and many of them are outside the limits of lethal fall-out. They can be readily converted into emergency general hospitals with reasonably good equipment and well-trained personnel.

Unfortunately, most states have no legislation which will allow these hospitals to be so used. Under present conditions, they are apt to be more of a menace than a help to the community, because no emergency legislation exists to provide for their continued function, let alone any augmented function, in time of disaster.

Assuming that, at least in many states, the state capital would be a target area and might be destroyed, it is difficult to see how state hospitals could continue to operate. Money to operate the hospitals is usually kept in the state treasury and in big city banks, and if these should be destroyed, it might be impossible to meet payrolls and to buy supplies. In such an emergency, the hospitals would run out of many supplies within hours or days. If patients could not be supplied with food and fuel, the hospital administration would then face the fearful alternatives of locking them up and letting them starve to death, or pushing them out of the hospital without care, which would also add greatly to the problems of the stricken community.

On the other hand, if the hospital continued operating, many of the patients could help care for the victims of disaster, and provide an excellent mobile blood-bank. For these reasons, the following emergency legislation was passed by the last Iowa Legislature. While the law does not guarantee the survival of the hospitals, it gives them at least a fighting chance for survival. Comparable legislation is strongly indicated in other states.

CHAPTER 165

Emergency Mental Health Institutions
H. F. 710

AN ACT to provide for the continued operation of the mental health institutes under emergency disaster, and to authorize their use as emergency general hospitals.

Be It Enacted by the General Assembly of the State of Iowa:

SECTION 1. In case of emergency disaster, with the infliction of numerous casualties among the civilian population, the mental health institutes are authorized to accept sick and wounded persons without commitment or any other formalities.

SEC. 2. The hospital is authorized to make a charge for these patients, in the manner now provided by law and subject to the changes hereinafter provided.

SEC. 3. In case the mental health institutes lose contact with the state house, due to enemy action or otherwise, the superintendents of the institutes are hereby delegated the following powers and duties:

(a) May collect moneys due the state treasury from the counties and/or from responsible relatives, or other persons, these funds to be collected monthly, instead of quarterly, and to be deposited for use in operating the institutes.

(b) The superintendent shall have the power to requisition supplies, such as food, fuel, drugs and medical equipment, from any source available, in the name of the state, with the power to enter into contracts binding the state for payment at an indefinite future time.

(c) The superintendent shall be authorized to employ personnel in all categories and for whatever remuneration he deems necessary, without regard to existing laws, rules, or regulations, in order to permit the institute to continue its old functions, as well as meet its additional responsibilities.

Such legislation probably will not be passed automatically by the state legislatures unless one or more members of both houses are vitally interested, and help to push it through. In Iowa it was introduced into the Legislature in 1957 and passed one house without difficulty, but died in committee in the other. However, in the 1959 session, delegates in both houses worked hard, and the bill passed without a dissenting vote.

It is desirable to have as many groups as possible supporting the passage of such a bill. State mental health associations can be quite useful, and local civil defense groups may work for such a law. The Director of the Office of Civil and Defense Mobilization in Washington, D. C., Leo Hoegh, furnished considerable help by long-distance telephone. A call to him at EXecutive 3-3300 in Washington would probably result in similar aid to any other state.

Photo (see also Cover) courtesy Good Housekeeping Institute.

Joint Setting for Research: Training School and University

By RICHARD L. SCHIEFELBUSCH, Ph.D.
Professor of Speech Pathology
University of Kansas
and HOWARD V. BAIR, M.D.
Chairman, A.P.A. Committee on Mental Deficiency
Superintendent
Parsons State Hospital and Training Center
Kansas

RESEARCH IN ALL MENTAL INSTITUTIONS is proceeding at a slow pace in general, but the lag in an area of research where progress could be more immediate—joint research between training schools and universities—is much too great. A comprehensive study of cooperative research programs maintained by training schools for the retarded and colleges and universities, published by Darrell A. Hindman in 1959 (3) showed that there were only four such centers carrying on reciprocal research. An analysis of other sources (2, 5, 7) reveals that cooperative research projects in mental hospitals are also few in number.

The primary reason for the lack of joint studies is not apparent, but a major stumbling block seems to be the stress encountered in achieving and maintaining satisfactory rapport between the cooperating agencies. Therefore, these somewhat sluggish conditions call for a frank discussion of cooperative research from both the institutional and the university points of view. Since the authors have been engaged in planning and implementing a cooperative project for approximately three years, the experience gained from it is the basis for this article.

Administrators, research workers, and hospital and university staff members involved in the development of a joint research program often find that finished reports of other projects are of little help. They do not reflect the obstacles encountered in planning and developing a particular project, and they do not explain how other researchers can repeat the generative processes that carried the study through its formative stages. Consequently, each new group of research planners from hospitals and universities must blunder through the same old problems without guidelines that might have been recorded by those who have attempted similar projects in other hospitals.

For this reason this paper will deal primarily with the problems of interagency *approaches* to research development, and it will be directed especially to those people who are shying away from joint research programs altogether because the problems of approach seem insurmountable.

The Problem: MUTUAL MISTRUST

People skilled in research procedures often seem to shun cooperative study in the unfamiliar and, to them uninviting, atmosphere of training centers for the mentally retarded. Likewise, administrators and staff members of these centers hesitate to seek help from research experts at neighboring universities. This indicates a need for information that might induce more research-oriented university personnel to turn to these training centers for research settings and might impel training-school personnel to invite university representatives to build research projects on training-school campuses. To fill this need at least partially and to reach a realistic approach—an overview of both the university and the training center scene—some of the issues involved in cooperative research development should be described.

Factor A. UNIVERSITY VIEWPOINTS

To begin with, the university research-trained person may assess the neighboring institution with a jaundiced eye because it has few personnel with research credentials. He may sense that its staff is "service-centered" and has little free professional time to devote to journals, research discussions, research projects, or attempts at publication. In some institutions he may encounter reluctance to join the research bandwagon; center personnel might hesitate to expose their service

programs to research scrutiny or to describe problems in the care and training of their children, that might be studied. The back-ward aide and the public-relations-minded department head may join forces in maintaining an outward show of confidence about the school's program of care and training.

At the same time, the university resource worker may know from recent reports that few aspects of the institution's program have received comprehensive research treatment and that, indeed, some critical issues have had none at all. Not uncommonly then, the university professor loses faith in the potential of the institution as a location for research activity, and hesitates to become involved in such activity or to be identified with the setting.

In some instances, the psychologist, sociologist, speech pathologist, or educational psychologist from the university may even be deterred from participating in training centers because of stereotypes built up through clinical feedback within his own discipline. His point may be that mentally retarded children learn or function in about the same way as "other" children but are limited to learning in fewer units and performing with less skill. Measured against normal children and the familiar indices provided by intelligence, social maturity, motor skills, achievement, or aptitude tests, the mentally retarded show unattractive deficits. Experiments in learning show them to make fewer changes in functioning than would be expected from normal children. When questioned carefully, then, prospective research personnel often confess a preference for working with normal children.

Factor B. TRAINING SCHOOL VIEWPOINTS

Professional staff members in institutions, in turn, view their university colleagues as "ivory tower" or as impractical would-be scientists who really do not know the ground-level facts about institutionalized children. In truth, they resent some of the "naive" assumptions implied in the "professor's" approach to retarded children. They ask, "How can an outsider really know mental retardates when he is unacquainted with their daily-care and management problems?" and usually recommend a period of institutionalized living for researchers who may view the training-school child as a research subject.

The "research" attitude of the university professional is, therefore, regarded with suspicion. If he wishes to be uninvolved and uncommitted to the hospital scene, he will probably be considered as hostile to or disinterested in the designs of the service program. These ideas may be covert and unspoken, or they may be the open topics of coffee talks throughout the institution.

The authors wish to acknowledge that these stereotyped attitudes do not now and have never entirely fitted the resident staff at Parsons State Hospital since the cooperative project began over three years ago. However, the differences are sufficient to establish the foregoing explanations as to why institutions for mentally retarded children are not frequently utilized as research settings.

Factor C. PLUS AND MINUS VARIABLES

The observer who places himself apart from the orientation of either group may see the half truth of both attitudes. However, if, in addition, he has been fortunate enough to participate in a cooperative program involving both, he will probably be inclined to dismiss the preoccupations described above as superficial and unnecessary. Instead, he will focus upon the bases for cooperation and agreement, and assume that there is a natural complementary process available to representatives from both sides, if they press forward together on a project plan.

The most obvious basis of compatibility is that the school has subjects, space, numerous researchable problems, and practical experience, while the university staff has research training, including a working knowledge of the literature, standards of research rigor, methodologies for design, and implementation and interpretation of research data. Thus, in exchange for essential elements of the research setting which the university does not have and cannot afford to build, the professor offers his skills and research experience.

This pooling of resources also promotes conditions which are likely to generate grant requests that ultimately will bring in new research resources and personnel, further enhancing conditions for productive, cooperative experiences. We therefore submit that the exchange is mutually beneficial.

In support of this assumption a brief of the experience compiled at the Parsons State Hospital and Training Center is offered. The project upon which the authors have coordinated their efforts is the Parsons Project in Language and Communication of Mentally Retarded Children. It was created through the joint efforts of the staff members from the Bureau of Child Research and related programs of the University of Kansas, and staff from the Parsons State Hospital and Training Center.

Formulated: THE PARSONS PROJECT

The actual project was preceded by a remarkable amount of discussion and planning which included a forthright acknowledgment of differences in objectives, value systems, and professional orientations. Once the views were aired, the planning committee members from each location felt confident about the stability of the undertaking and satisfied that the respective roles in the project would be beneficial to each and every member involved.

In advance of the active research phase, the planners agreed that the university would supply research-project supervision, consultant personnel, research assistants, data-processing equipment, and editing facilities. Parsons agreed to supply a suite of research rooms, and pledged administrative support, and staff cooperation.

The objective was to create a research center which could be maintained for an extended period of time so that substantive research development in important areas could be evolved and completed.

From the research programing the planners expected to derive a number of by-products. They felt that some important research would be published, and that research training in the setting would help a number of workers improve their skills for pursuing research in this and other settings. They anticipated that the project would challenge the resident staff and improve the morale of those working in various capacities at the center.

The excitement of the project was expected to feed back into the university setting and contribute individually and collectively to the staff there. Moreover, it was hoped that the combined approach to research in mental retardation would contribute to the field regionally, and perhaps nationally, by adding one more center to the list of those already available in the field. Finally, the planners were confident that an interdisciplinary research team would provide the strength to undertake research tasks ordinarily beyond the scope of a single discipline.

These points were all discussed and carefully considered before they were listed as anticipated benefits, and, after the study, reassessed and found to be realistic. In fact, the supporting staff members have frequently expressed pleasant surprise at the indirect productivity not even hinted at in the beginning. The resident staff seems increasingly eager to engage in research activity. Experience derived from the research effort has, in part, been responsible for the designing of a new rehabilitation unit at the hospital and for a research building in which personnel can eventually function more effectively in conducting research and in training new personnel to undertake research duties.

The project has aided the center's public relations. It has focused attention on the training school and helped to dispel the obsolete notion that such a school is a custodial institution where children are sent to be humanely managed, discrete from society. The project testifies that the problems of mentally retarded children are receiving intensive study and that in the future better programs of training may be available.

The conditions of the coordinated project, however, are not entirely desirable. The distance (approximately 140 miles) between the agencies requires time for travel, and also poses awkward problems in communication, purchasing, and recruitment of staff. Generally, the program evolved more slowly than the planners expected and the interaction of the project staff and the consultants is less continuous than anticipated.

However, the project staff finds that the inconveniences do not impair their functional ability to maintain the essential momentum of the project, and a fair assessment of the factors described seems to indicate that the advantages of cooperative research more than compensate for the drawbacks involved.

Recorded: PRINCIPLES OF PROCEDURE

The more than three years spent in the planning, implantation and research development phases of this project afforded numerous opportunities to observe and record useful information bearing upon the process of cooperative research:

(1) In all phases of an embryonic research project the two sponsoring agencies are likely to reflect different values and goals, but common ground can be reached through discussion and functional interaction.

(2) There should be careful planning, leading to agreement on the contributions and responsibilities of each agency. Fortunately there is a natural complementarity of function so that agreements are readily and amicably reached.

(3) A small administrative committee made up of one administrator from each agency and a representative of the project staff should assume responsibility for much of the formal interagency planning. They should work together in reviewing the project development and in restating agreements.

(4) The project undergoes continual modification which requires persistent monitoring by the administrative and research team members. They should learn to anticipate and to prepare in advance for difficult transitions.

(5) The research staff functions as a "department" within the institution. As such it plays a significant role in the life of the institution, and, in general, the research team should contribute to the research training of resident staff and to the public relations and morale building features of the institution.

(6) The cooperating agencies should provide wholehearted support of the research effort without impairing the autonomy of the research team in generating research. In short, the team members should not be captive to the administrative exigencies of either agency. •

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SELECTIVE JOB PLACEMENTS FOR PATIENTS

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WHEN THE MENTAL HOSPITAL evolves into an institution concerned with the welfare of the patient *in toto*, it will concern itself not only with his internal well-being, but also with preparing him to cope with the social world around him—community, job, and family—when he is released. Of primary importance is the relocation of the patient in a satisfactory job, but unfortunately this is the area in which he is least prepared by the hospital today. He is rarely tested in a realistic work situation or given training toward a specific trade or skill, and few systematic attempts are made to help him relocate vocationally.

As Bertram Black[1] states, "for the adult wage earner in our culture, his work environment represents by far the largest block of time in his working day. . . . Failure of the recent hospital patient to re-establish work patterns, then, leaves a vacuum of huge proportions in time, as well as economically and emotionally. . . ."

Prior to the interest of local offices of vocational rehabilitation in the state hospital—and this has been only in isolated instances because of the lag in local legislation—most endeavors to assist patients were on a trial and error basis, and performed mainly by social service departments. One can, however, find in the psychiatric literature and elsewhere sparsely reported programs which are more systematically conducted.

THE OSAWATOMIE PROGRAM

In 1958, the problem was approached at Osawatomie State Hospital by inaugurating a plan which attempted to coordinate job placement with discharge planning and industrial therapy in the state hospital. An earlier rehabilitation project[2] for patients who were blind had shown that such a plan was feasible and that community resources could be used to supplement the treatment and rehabilitation of patients. The rehabilitation committee which directed that program was made up of the superintendent and members of the medical, psychology, social service, and industrial therapy staffs. This committee quite naturally decided to shift its attention toward the vocational needs of the patient population in general.

A PILOT PROJECT

Some groundwork had already been laid in that the Kansas City office of the Kansas State Employment Service had helped to secure employment for several patients from its locale, but this aid needed to be increased because Osawatomie serves patients from twenty-two Kansas counties. Moreover, the planners felt that there were a number of long-term institutionalized patients in the hospital who could probably be discharged if suitably structured jobs could be found for them. It was also anticipated that the hospital industrial program could be oriented toward the occupational needs of the community, thus allowing the program some correspondence to the prevailing labor market.

With these objectives in mind the rehabilitation committee initiated a pilot project. In this collaborative venture, the Kansas State Employment Service placed at the hospital's disposal a full-time employment counselor who became an active participant within the hospital, living there and maintaining it as his home base.

At first, the committee served two principal functions: (a) to coordinate, communicate, and integrate the program into the hospital; and (b) to act as a screening board for patients referred to the program, i.e., to evaluate and approve patients ready for the job market and to make necessary suggestions for further treatment or for placement. This latter duty became superfluous, however, once the program was under way and the employment counselor had been assimilated into the hospital structure.

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[1] *Black, Bertram: The Workaday World: Some Problems in Return of Mental Patients to the Community, The Patient and the Mental Hospital. The Free Press, Glencoe, Ill., 1957, pp. 577-584.*

[2] *Appleby, Lawrence, and Bliss, Barbara: For Mental Patients Physically Impaired—A Hospital Program of Service, J. Rehab., 24:2:16-17, 47-49 (Sept.-Oct.,) 1958.*

Referrals for employment were screened through the social service department to the counselor, who worked primarily with the social worker and industrial therapist to gather information and assess the patients' work potential. The evaluation of a patient was focused particularly on his vocational assets. The concern was to make the best estimate of the individual's capabilities and prospects for outside adjustment within the limitations of his pathology and handicaps.

Early in the project it was felt that if fifty patients were placed in a year, it would be a substantial measure of success. The level of job performance was considered another standard, as well as length of stay out of the hospital. Since the project was not devised as a controlled experiment, though some crude statistics are available, impressions must be used to describe the findings. In lieu of a control group, base-rate discharge statistics for prior years were used on the assumption that with this type of project more of the chronically institutionalized patients (continuously hospitalized for three years or more) are likely to be discharged.

RESULTS ARE POSITIVE

During the first year of operation (February 1, 1958-January 31, 1959) exactly 100 patients were registered for employment. There were slightly more males than females, and 8 per cent were Negroes. The median age was around 45, and the average length of hospitalization, one and one-half years. Seventy-nine patients were classified as psychotic, with approximately 60 per cent of these considered schizophrenic.

Fifty of the total registrants were placed in gainful employment, and of this number, five day-night patients were in temporary occupations or part-time work. The sex distribution of those placed was almost equal, suggesting that it is easier to place women than men. Another interesting finding is that the median length of residence was about three years for those employed, indicating, then, that the actual population reached by this service was the chronically institutionalized—the initial aim. In fact, 40 per cent had resided in the hospital for five years or more. Also noteworthy is that 90 per cent of the patients placed had been diagnosed as psychotic, about 75 per cent of them schizophrenic.

Nearly 85 per cent of the patients placed were in unskilled or semiskilled jobs, such as farm labor, domestic service (nurse maid or general maid), laundry labor, and waiting tables. The remainder of the placements were distributed among skilled and clerical positions. The average yearly earning was approximately $1700, 62 per cent making between $100 and $125 monthly. Only 25 per cent earned more than $150 a month. The lower salaried positions were those in highly structured and protective areas of employment such as nursing homes, farms, and private homes where the patients lived in residence. They were usually paid anywhere from $30 to $80 monthly including room, board, and laundry. These work situations are well suited to the chronic pa-

tient, who has long been dependent on a closely supervised social framework, with little demanded of him.

The total earnings of the patients placed during the first year amounted to $24,417, and the state of Kansas was spared the expense of 5,763 patient-days during which the patients were not in the hospital. This savings, at the rate of $5 per day per patient, amounted to $28,815. These figures do not, of course, reflect the additional savings gained through the avoidance of welfare aid and nursing home placements, and by direct revenue returned to the state in sales taxes, income taxes, etc.

Two weeks after each patient's placement, follow-up calls were made by the counselor to elicit the employer's opinion of the performance of the employee and his general adjustment. Seventy per cent of the employers were highly satisfied with the quality of work, rating the ex-patients either "good" or "very good." Only 10 per cent of the employees were felt to be "poor" or "very poor" in their job performances; 16 per cent were rated "adequate."

To further assess the program, twenty-six of the patients placed during the first six months were followed up for the remainder of the year. Only six, or 23 per cent returned to the hospital; 77 per cent remained out; and 70 per cent are still employed. Two of of the six returning patients came back for hospital reasons (the patients were mistreated), so there were only four actual job failures. These were due to lack of sufficient work or to the inability of the patient to meet the performance standards of the job. Two other patients left their jobs and were discharged from the hospital. Eighteen of the twenty-six patients worked more than six months.

SUPPORTING DATA

The following data, showing the number, dispersion of discharges, and total resident population of chronic patients potentially available for the labor market in 1956, 1957, and 1958, substantiated the prediction that more chronic patients would be discharged during the year of the program than during the prior two years. In 1956, there were 805 resident patients and 86 releases; in 1957, 765 resident patients and 97 releases; and in 1958, 705 resident patients and 127 releases. That there is no normal increment in discharge from year to year is demonstrated by the fact that no statistical significance was established by comparing 1956 and 1957. Further evidence is that the percentage of releases in 1955 also failed to differ from that of 1956—indicating that a stable three-year period existed prior to the job-placement program. In addition, the sex-ratio remained fairly constant among the dischargees.

Further, the results which were obtained could not be accounted for by variation in the number of personnel at the hospital, because there was a fairly uniform number of physicians and social workers during the periods under scrutiny.

Although a higher percentage of chronic patients returned to jobs during 1958 (25 per cent, or 32 patients) than in 1956 (11 per cent, or 11 patients) the compari-

son between 1958 and 1957 (21 per cent, or 20 patients) did not yield a significant difference, despite a 4 per cent increment. However, this slight increase in 1958 suggests more confidence in the program in view of the fact that 1958 was the poorest employment year in some time, according to regional labor statistics. It is conceivable that the results would have been better in a year with a "normal" labor market.

The results presented speak for themselves, and need little interpretation. However, some qualifications should be made. First, the findings should not be considered as definitive. Only controlled research in the future will bear out their validity. Second, the results of the program should not be attributed solely to the employment counselor, because social service and industrial therapy people played an equally prominent role in finding openings and helping to place patients.

One important factor, however, was that a "spread effect" occurred—a larger number of people became interested in finding jobs for patients. Obviously, a competitive element accelerated this, but so long as it remained constructive and well integrated in the project's framework, it was beneficial to the hospital.

Finally, it is difficult to say whether the increase in the discharge rate was a direct consequence of the program or of other considerations. Certainly the changing philosophies of the hospital have much to do with the treatment and discharge, but the introduction of such a program may alter the hospital structure so that philosophy and emphasis change. A new project opens new avenues that may be used and stressed. For instance, when the presence of the counselor became widely known, patients, without referral or permission, sought him out and requested employment applications.

As originally conceived, the plan was to prepare patients for the industrial needs of the community and to regulate the industrial therapy program along these channels. Consequently, there now exist several types of specific job-training: laundry work; housekeeping; typing and clerical work. Together with these expansions there has been increased emphasis on part-time employment, and day-night patient care.

These rather modest and economical innovations represent a concerted effort to aid mental patients in regaining their self-confidence and a place in the community. The social worker, industrial therapist, and vocational counselor combine their skills to train workers, find jobs, place patients in suitable environments, and provide emotional support while the ex-patient begins anew his life in the community. •

Have You Heard?

TRAINING & RESEARCH: At the annual meeting of the *Western Mental Health Training and Research Council of WICHE,* held this past summer, members of the council considered several new proposals, including a five-year project for regional training and research centers in juvenile delinquency, and a three-year regional staff development project for public mental hospitals and schools for the mentally retarded. The council reviewed its Summer Work-Study Program in Mental Health for college students, started at the University of Colorado and at the University of Washington, and its regional training program for career employees in mental retardation at Pacific State Hospital, Pomona, Calif.

The council recommended that the former program be expanded by adding institutions and hospitals in neighboring states to the field work programs of the two current courses, as well as by developing new programs at universities in other states. It also recommended that an advanced summer work-study course in mental health research training for graduate students be developed.

The council also voted to develop a committee for professional education in community mental health work, which would sponsor training programs for community workers in the promotion of mental health and the handling of problems of human behavior and emotional disturbance in home, school, and business environments.

An NIMH Project Grant, totaling over $150,000, was recently awarded through the Menninger Foundation for research to be done in Kansas, at the Osawatomie State Hospital (George Zubowicz, M.D., Supt.) The three-year program, to be known as the *Osawatomie Social Systems Project,* will be a study of the manner in which the mental hospital affects new personnel in their work with psychiatric patients. It is hoped that "studies such as this will in the future aid in providing more satisfying jobs in the hospital setting, and at the same time greatly increase the therapeutic efficiency of employees." Several outstanding authorities in the fields of sociology, social psychology, anthropology, and nursing will serve as consultants to the project.

NEW BUILDING AND SERVICE FOR THE AGED: A unit for geriatric patients was recently opened at *Compton Sanitarium* (G. Creswell Burns, M.D., Supt.), Cal. This unit has fourteen individual rooms. Patients can be out-of-doors a good part of the time in an enclosed patio. Only ambulatory patients are cared for in this separate section.

The U. S. Public Health Service has announced the establishment of a *Nursing Home Service Section* as a part of the Chronic Disease Program, Division of Special Health Services, Bureau of State Services. Under the direction of Dr. Bruce Underwood, section chief, this service will provide consultation on clinical services, administrative management, and licensing of nursing homes and homes for the aged, and will conduct studies on the needs for services in such homes.

DEVELOPING CLINICAL PSYCHOLOGY IN NEW ZEALAND

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TO COME TO A NEW COUNTRY and to set about developing teaching and research in the applied aspects of one's subject can be a fascinating experience. At the same time it can lead to a multitude of frustrating situations. On the one hand there is the challenge of virgin fields with no hampering traditions to mar schemes for their development. Against this must be weighed the ignorance, the apathetic attitude, the lack of facilities, funds or staff, all of which prevent dealing adequately with the many problems which emerge.

Such is the situation in which, during the last three years, I have found myself. My task has been to develop the applied aspects of psychology in the University of Canterbury. Although I am writing now only of the clinical side, my work also includes industrial and vocational psychology.

Prior to 1957, applied psychology in this area was almost entirely organized by the education departments of the various universities, and could not properly be called clinical psychology. The mental hospitals of the country employed no psychologists and there were none in private practice. Children were reasonably well catered for (although we have found a demand for extended services in this area), but there was very little offered to the average mentally disturbed person. The Justice Department employed a few psychologists, but one could hardly recommend that a patient commit a crime in order to obtain psychological services!

Against this background, there has developed a growing awareness of the needs of the emotionally disturbed, an awareness expressed spontaneously by the public in the formation of mental health associations, and more formally by mental hygiene authorities in the establishment of posts in clinical psychology.

DEVELOPING AN ANSWER

So far our approach to the problem has been twofold. First we established an Applied Services Division of the Psychology Department, complete with a small clinic. This clinic handles psychometric and general clinical casework, in spite of staff shortages and inadequate facilities. Its major use is in providing teaching staff with opportunities for practical work, and with case material, without which it is my firm belief that applied teaching cannot be tackled. The educator must retain his competence in "doing" if his teaching is not to suffer. Apart from this important function, the clinic provides cases for supervised practice by students. Finally, it serves the oft-forgotten yet important function of fostering good relations with the general public. In developing applied psychology of any sort, one must consider not only the students' skills but the public's attitudes as well.

Following the establishment of the clinic, our second approach was the logical one of offering an M.A. degree in clinical psychology. The New Zealand M.A. degree is a two-year postgraduate course for students who have obtained a B.A. degree in their chosen subject. For the clinical M.A. students are required to write four papers in the first year. Two of these, clinical psychology and psychometrics, are mandatory. These are combined with not less than twelve hours' practical work each week. In the second year, they must either produce a thesis or carry out a series of case studies to a requisite standard. The aim of the degree is not to achieve the acme of perfection in applied training, but to acquire basic and adequate training in the theory and practice of "doing the job." Already we are thinking toward a future goal—a joint arrangement whereby part-time work in the university and inservice training at various other establishments and hospitals will lead to a Diploma in Clinical Psychology.

THE ROLE OF THE CLINICAL PSYCHOLOGIST

These are the present and possible future mechanics of training. Important though these are, much more interesting is the theoretical question of just what sort of person a clinical psychologist should be. How should clinical psychology develop? What sort of role do we have for the clinical psychologist? Some people, though perhaps not many, would glorify the psychologist into the position of a mental health deity, arguing that his study of human behavior of all sorts equips him better than any other to understand and treat emotional and other mental health problems. Others would relegate him to the role of a junior technician—a simple "I.Q. basher." His true role, of course, lies somewhere in between, the basic problem being whether he should be a diagnostician or a therapist.

In our view here in New Zealand, the psychologist is not to be regarded simply as a technician, to be called upon by a medical practitioner to administer certain specified tests. The psychologist should be competent to select appropriate assessment techniques in order to obtain, on any individual patient, a full and comprehensive diagnostic case report. And for this task, the psychologist, by virtue of his particular training and experience, is the best qualified professional. Some people argue that a complete diagnosis is not necessary, on the grounds that therapy of a certain sort, which is concerned with developing the present personality in the therapeutic situation, does not require diagnostic knowledge. In answer to this, I would say that the more serious an illness, the greater the need for comprehensive and accurate diagnostic knowledge. Unless a therapist knows

exactly what he is dealing with, its extent, particular areas and causes, he does not know whether a certain treatment technique is appropriate.

The psychologist's role in treatment depends on one's theoretical viewpoint. If one leaves out of consideration the techniques of child therapy, residential care, and adult role-playing, does the psychologist have any further role in treatment? Obviously he cannot be considered legally or professionally competent to engage in any physical techniques or in drug therapy. It is in the area of what is normally regarded as psychotherapy that there are conflicting opinions about the psychologist's role. My own viewpoint is first to make a distinction between "therapy" and "counseling." To understand this division, one must take into account my theoretical viewpoint about behavior and disorders. I hold that there is a continuum from normal to psychotic behavior, with general neurotic behavior in the center of this continuum. "Counseling" I hold to be a technique appropriate for use with patients who can be classified as neurotic, leaving "therapy" for the more inaccessible psychotic disorders. It is not the same technique applied to different types of disorders, but a distinct method. Counseling is based on the premise that the neurotic, for whom it is meant, will be sufficiently in contact with the real world to take an active part in his own therapy.

THE PEDESTRIAN APPROACH

Having outlined a specific role for our psychologist, we must now say something of what sort of diagnostician or counselor we want him to be. This may be summed up quite simply by saying that in diagnosis we want him to take the pedestrian approach. We do not want vast armchair speculations, deep hypothetical analyses, or vague theorizing. If the diagnostician is to analyze and predict behavior, he must do so on the basis of sound empirical evidence, through adequately standardized assessment techniques. Similarly, in counseling we wish him also to take the pedestrian approach, neither analytic and interpretational, nor yet wholly nondirective and relational. Both of these may be regarded as extremes, neither of which is appropriate for the level of emotional problems with which he is concerned.

In counseling the neurotic, our psychologist learns to use a carefully structured interview. Basically, three major aims are held and the counseling interview is organized in an attempt to achieve these. First, we suggest that there is a general cathartic effect in simply talking out one's problems. It might be argued that this would be just as effective if the patient were to talk into a microphone, or indeed if he were to kneel down to pray, but the additional value of catharsis in the interview situation is the personal contact and the steering of the interview, which allows patients to "give out" their problems.

Related to this is the second aspect, which suggests that part of the counseling effect is achieved simply through the interpersonal relationship of counselor and client. In the establishment of a relationship with a sympathetic, but not personally involved, listener, the patient finds a supportive value which enables him to overcome his problems more readily. Simply speaking, he is no longer alone.

The final use of our counseling method rests on the nature of most neuroses. The neurotic person, finding the buzzing, fuzzing world in which he lives too much for him, has just stopped trying. The counselor stands aside, and through his training, is able to isolate the patient's difficulties. His role is to "clarify the issues" and so to lead the patient to a solution of his conflicts.

THE AIM

What I have been saying illustrates the development of two central aspects of the clinical psychologist's training. They are probably the most important aspects, and for this reason they have been the first we have tackled at Canterbury. Our aims must obviously be extended in the future, but any widening of the psychologist's training must, to my mind, await the further development of other fields. When this has been achieved, we can then plan for the psychologist to be a member of a team which will offer distinct yet complementary services to the community. Within this team, the psychologist's role will be diagnostic and therapeutic within the limitations I have outlined.

If my ideas conflict with your notions of what a psychologist can do, remember that you live in a fully developed land, while my virgin fields have no furrows to hold me to an already set line. This is my gain. If you feel my approach to be too pedestrian, I can but suggest that it is devised to offer, without frills, the most useful service possible within the bounds which are practical. •

Morning In Bed

AMIDST THE MANY HOSPITAL ACTIVITIES geared to the rehabilitation of the patient to home and community living, we sometimes forget the value of an occasional lazy "morning in bed." "Early to bed and early to rise" is an old tradition, well practiced in hospitals, but the Jamestown State Hospital in North Dakota has tried to break with tradition by allowing those patients who wish, to "sleep in."

The plan was first presented to and accepted by the staff, and then by the patients. On their specific "day off," patients would be able to stay in bed as long as they pleased and would make their own coffee and toast. The kitchen got the food requirements beforehand, the night nurse was told whose day off it was and the change-over was easily accomplished.

Service was still available as needed. For the few areas where early morning assistance was required, the "days off" were staggered for patient-employees.

Now throughout the wards one hears many pleased remarks about "tomorrow I won't have to get up." There has been such an improvement in the patient-morale that it makes us wonder why we did not try this experiment a long time ago.

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Psychological *Side Effects* of a Drug Study

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CERTAINLY THERE IS NO DEARTH of accounts about research projects designed to determine the superiority of one drug over another, or to examine the peculiar properties of a drug isolated by the use of a placebo. Too often neglected, however, is the fact that such research projects may also serve to induce both staff and relatives to take a new interest in the patients. Indeed, the patients themselves frequently become actively interested in the project. Sherman[1] has said that psychopharmaceutical research should properly consider the variables not only of the drug, but also of the situation and the personal factors of a patient's response to it. As he points out, "It is necessary to specify the total social situation in which any drug experiment is carried out." Evidence of the importance of the attitudes of the staff has been amply attested to by Feldman,[2] and Thorpe and Baker.[3]

The purpose of this paper is to describe a research project which attempted to maximize the involvement and interest of: (a) the immediate and tangential staff members, both professional and nonprofessional; (b) the patients involved as subjects in the study; (c) the relatives of these patients; and (d) less directly, all the patients on the unit and their relatives.

In the latter part of 1959 this hospital began a research project to compare the relative effects of two phenothiazine tranquilizers and a placebo. Since each subject was to serve as his own control, (taking each of the drugs being tested and the placebo at different stages of the study) the research staff felt that it would be possible to involve a large number of people and still be able to ascertain the relative effects of the drugs.

The first step in this project was to establish an average typical dosage for the two drugs. With the cooperation of the patients themselves, the staff tried varying dosages, until they were satisfied as to what constituted the optimal dosage of each drug for the majority of the patients.

Following this, all staff members who were to be involved in the project participated in a series of meetings. This group included the ward attendants, the rehabilitation therapists, the hospital pharmacist, the hospital laboratory technicians, the psychiatric nurse and three student nurses attached to the unit, three social workers and two psychologists assigned to the unit, and the psychiatrist in charge of the unit. In these meetings each individual learned his own role within the over-all research design. A number of members made suggestions as to how families could best be involved, how three identical-appearing drugs could be dispensed with the minimal amount of error, and how to accomplish necessary administrative procedures.

PATIENT HELP SECURED

The unit psychiatrist then contacted all eligible patients individually, and asked them to help the staff in evaluating the two new drugs. (Eligibility depended upon the nature of the illness and the length of hospitalization.) A few of the patients declined to cooperate, but approximately 90 per cent were quite willing to be participants. The number of "reality-oriented" questions concerning the nature of the drugs, the possible findings, and implications of the research was surprisingly large and gratifying.

The social workers then notified the family of each participating patient that its relative had agreed to take part in the evaluation of two new drugs. Then, when the patient went home on a weekend visit, his family would answer a questionnaire about his behavior, which enabled the staff to evaluate any changes which may have taken place. In addition, relatives and interested visitors attended bimonthly unit family days and received a general description of the research project.

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[1]*Sherman, L. J.: Amer. J. Psychiatry, 116:208-214 (Sept.) 1959.*
[2]*Feldman, P. E.: Amer. J. Psychiatry, 113:52-54 (July) 1956.*
[3]*Thorpe, J. G., and Baker, A.A.: J. Ment. Sc., 102:790-795 (Oct.) 1956.*

Working independently from one another, the psychiatric nurse, the rehabilitation therapist, the psychiatrist, and the ward personnel evaluated each patient's mood, interest in ward and hospital activities, changes in work performance, and changes in behavior and attitude in rehabilitation therapy groups. The pharmacist diligently played his role in dispensing the correct drugs to the ward personnel, according to the prescribed experimental design. Only he knew the identity of each capsule.

SIDE BENEFITS

Although the results of the study of the two tranquilizers and the placebo are yet to be determined, the effect of the research project on patients, families, and staff has been remarkable.

The project has been the subject of discussion in patient government meetings on several occasions. A number of patients located in other areas of the hospital have expressed a desire to be on wards where "they are really doing things." Some patients who were not included in the research group have expressed animosity at being left out, while others have berated the experimenters for using their fellow patients as "human guinea pigs." Attendance at the most recent family day was one of the largest in recent times. A number of families who had previously shown little interest in their relatives began writing the hospital more frequently and asking to have them home for week-ends.

Similarly, the staff has shown an increased interest in hospital activities; over-all staff morale is better. Attendants have voluntarily stopped taking time off on "critical days" of the experiment. The student nurses proposed writing a paper on their perception of different aspects of the research, instead of their usual term paper. The social workers volunteered to gather considerable data from the patients' folders concerning length of hospitalization. The majority of the personnel and participating patients seemed to develop a personal involvement in the research project, affording them an interesting and exciting venture. In short, the drug study served as a catalytic agent to enhance all phases of the therapeutic climate. •

A *Directive* or a *Permissive* Approach?

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When it comes to working with long-stay schizophrenic patients, psychiatric nurses receive a surplus of advice but an acute shortage of reliable data. Depending upon the individual psychiatrist, nursing instructor, or textbook, nurses are advised to be permissive, directive, protective, understanding, motherly, or fatherly. In the absence of clear experiments on the best ways for motivating regressive patients, nurses and aides have no alternative but to accept all the advice offered and try to resolve the inconsistencies, ambiguities, and banalities. It is also unfortunately true that in psychiatric nursing there is a dearth of methods for deciding whether advice is good or poor.

The present study is an attempt to evaluate empirically two of the most persistent problems that confront psychiatric nurses and aides. The first question is whether a directive or permissive approach will result in greater patient participation in ward activities. The second question concerns the relationship between the number of staff engaged in an activity and the number of patients who participate. That is, does an increased number of staff assisting in an activity increase the number of patients who participate?

Many may feel that the answer to the last question is obvious, and that there is no doubt but that more staff will result in greater patient participation in activities. Unfortunately, the little evidence that exists does not support the idea of a direct relationship between the number of staff and the amount of patient participation. In our own hospital, we have wards which resemble sponges in that one, two, or three additional nurses can be assigned without any noticeable effect. One of the few empirical studies of staff-patient ratio was done by M. Gutenkauf and W. Lundin and reported in the American Psychologist (13:336 [July] 1958.) under the title "Emergent Differences Between Two Experimental Ward Cultures as a Function of Staffing Ratios." Using two wards, each containing similar patients but one having twice as many staff as the other, they found no significant differences in the patients' condition. In fact they found more disturbances and problems of management on the ward with the greater number of staff. These results do not mean that mental hospital wards could be improved by decreasing the number of nursing staff, but rather that we should not expect a direct increase in patient improvement simply because the number of nurses and aides on the ward is increased. Even more, the results indicate the need for research on the effects of various kinds of staff-patient ratios.

As to the question of a directive or a permissive approach, the problem of motivating regressed patients to participate in activities is made more difficult by conflicting advice and ambiguous terms. As far as we know, no one has ever attempted to find out how many patients will attend activities (a) when they are given a choice without any coaxing, (b) when they are coaxed with verbal encouragement, and (c) when they are led by the hand. These methods can be considered the polar conditions along a permissive-directive continuum. Another possible method of motivating patients to attend activities involves the use of small rewards of candy and cigarettes. It is assumed that such rewards given selectively for participation will make activities more pleasurable to the patients.

The study reported here had, then, two major goals:

1. To learn the effects of a permissive and a directive approach upon the amount of patient participation in ward activities, and also the effects of using small rewards of candy and cigarettes.

2. To learn whether there is any relationship between the number of staff engaged in an activity and the amount of patient participation.

METHOD

The study took place in a 1500-bed mental hospital on a special research ward established to try out new nursing techniques. The ward is an autonomous administrative unit established by the clinical director. It is under the administrative control of a research psychologist who receives medical advice from a psychiatrist. The 40 patients on the ward are all long-stay, female schizo-

phrenics who have not responded to drugs or other treatments. There is a relatively favorable staff-patient ratio, with 5 nurses and aides on the day shift, 3 on the afternoon shift, and 2 on the evening shift. A trained activity therapist is present three afternoons a week.

The ward has a comprehensive activity program which includes rhythm band, bingo, folk dancing, exercises-to-music (eurhythmics), bowling, and ball tosses. These are conducted by the ward staff with the occasional assistance of the activity therapist. Each day there are from seven to nine activity periods of about 25 minutes each. Longer periods are felt to be less effective in maintaining the interest and participation of regressed schizophrenic patients. The activities listed have been used on the ward for some years. The only changes made during the experiment were to specify a particular manner of approach to the patients and set a particular time-period for each approach.

Directive approach—During the first five weeks of the study, nurses were instructed to ask patients to participate in activities, and, if a patient remained silent or was hesitant, to ask again and then lead hesitant patients over to the activity area. Many of these patients were so withdrawn and regressed that they would not come even if led by the hand. Needless to say, "leading by the hand" did *not* include tugging or pulling the patient. Records were kept of the number of patients who participated (a) with only verbal encouragement and coaxing, and (b) after being led by the hand. The number of staff engaged in the activity, the duration of the session, and the number of patients who stayed until the end were also recorded.

Permissive Approach—During the next five-week period, nurses were instructed to ask patients whether they would like to participate in activities, but to use no further verbal coaxing or leading. The directions to the nurses were as follows:

Approach the patient and say, "We are going to have (rhythm band). If you would like to join us, come over to the piano." After this, go to a specified location, wait no longer than three minute to start the activity. If after two more minutes there are no participants, terminate the activity. If you have even one participant, continue with the activity just as usual.

Records were kept of the number of patients participating, number of staff involved, duration of activity, and the number of patients who stayed throughout the session.

INTERIM MEASURE

Permissive approach plus reinforcement—The following two weeks were devoted to the use of a directive approach plus gifts of candy and cigarettes to patients who participated in activities. This was considered an interim period. Attendance had declined so markedly during the permissive sessions that simply giving rewards to those few patients who still attended activities would not have been an adequate test of the effects of reward. Hence the directive approach was reinstated for this time-period so that the greatest number of patients

would be apprised of the fact that they would obtain candy and cigarettes for participating in ward activities.

Following these two weeks there were five more weeks in which a *permissive* approach was used along with candy and cigarettes as rewards for participation. These rewards were given in the middle of each period of rhythm band, folk dancing, bowling, and eurhythmics. They were not given for walks or trips to the canteen, since patients who left the ward would have the opportunity to purchase cigarettes or candy themselves. The actual instructions to the nurses were similar to those used during the *permissive* sessions with the following addition:

Reinforce the patients who are participating (e.g., one cigarette or two pieces of candy per patient per activity) while you are still in the middle of the activity.

RESULTS

Participation in most of the activities declined markedly when the permissive approach was used. The average attendance at rhythm band, dancing, bowling, and eurhythmics fell 50 to 80 per cent when nurses asked the patients to participate without coaxing or leading them. In all these activities, coaxing secured twice as many participants as a permissive approach, and leading by the hand raised attendance another 50 per cent. When cigarettes and candy were given as rewards for participation during the last five weeks of permissive sessions, attendance exceeded that of the permissive sessions without reward, but did not reach the attendance attained during the directive sessions.

The only activities in which coaxing was not superior to the permissive approach were going for a walk and going to the canteen. In both cases, approximately the same number of patients participated under each approach. However, when patients led by the hand were included in the total, twice as many went for walks with the directive approaches as with the permissive approach. It is interesting to note that both of these activities—going for a walk or to the canteen—involve patients leaving the ward. This suggests that a permissive approach has its greatest utility when the activity is "pleasurable" to the patients. The sharpest decline in attendance took place in activities in which active patient participation is required.

The number of staff engaged in an activity was decided by the nurses in consultation with the activity therapist. The records showed that the average number of staff engaged in the rhythm band was three, while the average number participating in folk dances was closer to four. Going for a walk involved two staff members; trips to the canteen, only one. In no case was there a really large difference in participation that could be attributed to an increase in staff assisting with the activity. For example, when two staff led the rhythm band, the average number of patients attending a session was 9.4; with three staff, the average participation was 9.7; and with four staff, it was 10.6. This is a very slight in-

crease and is not statistically significant. The same trend is found in both directive and permissive approaches with all activities. However, it should be remembered that the number of staff varied within very narrow limits. Our conclusion that the number of staff does not materially influence patient participation applies only to the number of staff actually used in the activities. It is possible that if only one nurse had conducted a rhythm band session, patient participation would have been affected.

DISCUSSION

These results show that a permissive or *laissez-faire* approach is inadequate as a method of encouraging regressed schizophrenic patients to engage in such activities as dancing, bowling, and rhythm band. When the patients were asked to participate without coaxing or leading, there were more than a dozen sessions in which *no* patients participated. This total lack of participation was discouraging to the nurses, many of whom wondered when the permissive approach would be dropped. In some cases these were the same staff members who had advocated "giving the patients a choice" during the previous directive sessions. But when the permissive approach was used with rewards, participation improved.

It is interesting to note that the five weeks of permissive approach followed five weeks of directive approach. One of our colleagues suggested that attendance during the permissive period would be high because the patients would have developed an expectation from the directive period that, if they didn't attend when asked, the nurse would lead them anyway. The sharp drop in attendance at permissive sessions shows that this carry-over did not occur.

DANGER OF DEPENDENCE

The results also indicate that in order to maintain attendance of regressed patients, it is necessary to continue coaxing or leading them to activities. However, this has the drawback of encouraging patients' dependence upon the nursing staff. On the other hand, failure to use the directive method leads to a sharp drop in participation, inasmuch as this participation is a product of the continued interest and leadership of the nurses. Since leading patients by the hand soon becomes onerous and distracts the nurses from other duties, a more desirable alternative is to use the permissive approach but follow it with candy or cigarettes as rewards for voluntary participation. As has been demonstrated, this method results in greater participation than the permissive approach without rewards. To be effective, however, the permissive approach with reward must be preceded by a directive approach in order to get maximum patient participation. The patients must be brought to the activity to receive the rewards. If they never come to the activity (and this is likely to happen if a permissive approach is used initially) participation cannot, of course, be rewarded. Another encouraging finding is that patient participation can be maintained even with a permissive approach in some kinds of activities—in this case, outside walks and trips to the canteen. It is important for us to learn more about the kinds of activities that patients will engage in without constant supervision.

EFFECTS OF STAFFING

A third finding was that on this type of ward the ceiling of patient participation is reached quickly. Increasing the number of staff assigned to activities makes very little difference in the number of patients who participate. This is an interesting result in view of a continued pressure from all wards for more staff. We have already mentioned the finding by Gutenkauf and Lundin that on their two wards an increase in staff did not result in an appreciable improvement in the patients' condition. As a result of our study, no activity using more than two nurses is carried out now on this particular ward. Unless it can be shown that a second or third staff member improves the *quality* of patient participation, it would be more logical to have the additional staff member conduct a new activity.

In conclusion, these results do not provide any information as to which activities are most therapeutic, nor are they intended to. They tell only how to get patients to participate, which is quite a different question. It is highly possible for a ward staff to be sure that certain activities must be therapeutic, but still lack the techniques for getting patients to participate in them—and if the patients don't or won't participate in a given activity, the therapeutic potential of that activity is bound to remain an unknown quantity. •

REVIEWS & COMMENTARY

FILM REVIEWS

The Mental Hospital Service film library now has 28 films available at a nominal handling charge to all full subscribers to the service. The two latest additions to the library are THE PHYSICIAN AND MENTAL HEALTH, produced by the Southern Regional Education Board, and THE OWL AND FRED JONES, which is reviewed below and which non-subscribers may be able to obtain from the film libraries of their State Departments of Health. (MHS subscribers are reminded that film requests will not be honored unless order forms are used.)

THE OWL AND FRED JONES (color, 15 minutes) Produced by Equitable Life Assurance Society of the United States, 393 Seventh Avenue, New York 1, N. Y.

Equitable's Bureau of Public Health has come up with an imaginative animated cartoon which attempts to make people more aware of the part that habit plays in their lives. Fred Jones, father of three and in his mid-thirties, admits that he is a "creature of habit," but he has one particular habit—overeating—which he would like to change. On a midnight walk, he encounters the Owl (who has apparently read William James's essay on habit) and is given some rules for habit change. In order to reach the point of conversion, Fred must first make a list of the pros and cons. Once he's decided to change, he names a specific "Starting Day." To avoid putting undue strain on his behavioral routine, only one habit change at a time is attempted. When the new habit pattern has been started, no exceptions are permitted. However, after his confidence has been established, he feels safe enough to be exposed to the temptations of the old habit, because each refusal of this temptation reinforces the new behavior pattern.

THE OWL AND FRED JONES does not attempt to explore psychological factors behind resistance to change, but, on a strictly behavioral level, this attractive little film makes its points clearly and amusingly. The habit pattern in the film is overeating, but the prescription for habit change could apply to a wide variety of personal and work habits. For this reason, THE OWL AND FRED JONES might be used in mental hospitals by nursing supervisors to inculcate better nursing routine habits in nurses and aides. It is possible that the film might also be useful in group therapy sessions with patients about to be discharged from the hospital—even though it was not made specifically for this purpose. In those hospitals where there are regularly scheduled informational film programs for the staff, this film would provide an entertaining and instructive quarter-hour, although the message would be driven home more effectively if the film were followed by a discussion. This colorful, stimulating cartoon is a thoroughly professional job. In addition, Equitable supplies a discussion guide and a batch of posters to help those who make use of the film.

JACK NEHER
Mental Health Materials Center

BOOK REVIEWS

GERIATRIC NURSING—by Kathleen Newton, R.N., 3rd Edition, St. Louis, Mo., The C. V. Mosby Company, 483 pages, $6.50.

For some time those interested in the care of the aged have needed a text in keeping with the new concepts of nursing. Kathleen Newton has made revisions in her text "Geriatric Nursing" which are in accord with the wide general educational background necessary in approaching any nursing speciality. The book does not attempt to present a complete discussion or intensive instruction, nor does it indicate the allocation of duties to professional or subprofessional groups.

The first section considers the psychological focus at work within the aging individual. Social attitudes, and how they affect care and progress during illnesses are discussed. The primary purpose of this section is to present a firm foundation upon which a nurse may build an intelligent and emphatic nursing care plan. The second section includes chapters on nonspecific subjects that affect most elderly people. The third deals with the more common clinical conditions that need emphasis in the minds of those caring for the aged. An integrated approach has been used to discourage compartmental learning and to illustrate the application of specific content to all nursing experience.

The book has been planned primarily for those who nurse the aged. It is an attempt to give an overview and prepare us to meet new situations resulting from the age shift in our population. If an understanding of the psychological and social factors affecting the aging will aid the nurse in her portion of the rehabilitation program, then this text will be a useful reference for all.

ROBERT E. FULLEN, R.N.

CURRENT STUDIES

This column lists reports on investigations of interest to mental hospital personnel. Authors have agreed to make copies of their papers available, and requests should be sent to them directly, with 25¢ for postage and handling (unless otherwise indicated). The Editor wishes to point out that these studies have not been evaluated by A.P.A.

PSYCHOPHARMACOLOGY—A Pictorial Exhibit of Two Studies in a Mental Hospital Setting. The two studies "A Preparatory Study of Clinical Research Methodology" and "Drugs and Moral Treatment" were conducted at St. Elizabeths Hospital, Washington, D. C., where the National Institute of Mental Health has located its Clinical Neuropharmacology Research Center. The studies were designed primarily to investigate the effects of newer phenothiazines on chronic schizophrenic patients. In practice, they were also a direct test of the feasibility of conducting research in a large mental hospital setting. Copies of the booklet available from Dr. John G. Lofft, William A. White Service, St. Elizabeths Hospital, Washington, D. C.

NURSING SERVICES AT MENDOTA STATE HOSPITAL—Recommendations for Management Improvements—Jack L. Christian, Office of the Director, Wisconsin State Department of Public Welfare, June 1960. Although these recommendations are made for the nursing service of a specific hospital, certain ones may be of interest to other institutions. For example, recommendations are made for consolidation of the clerical and administrative functions on the ward; for reorganization by the nursing service of its supervisory structure in accordance with the service team; for a major study of aide classification; for improvement of communication channels within the nursing service; for a formal study of the application of team nursing; for the preparation of a master plan for each building, listing uniform procedure and location of physical facilities on each ward.

ADMINISTRATIVE CONCERNS IN A PUBLIC MENTAL HOSPITAL CHAPLAIN PROGRAM—Rev. Ernest E. Bruder, Coordinator, Chaplain Services Branch, St. Elizabeths Hospital, Washington, D. C.; issued by the Academy of Religion and Mental Health: available at the A.P.A. Publications Department, 1700 18th St., N.W., Washington 9, D. C.

AFTER-CARE SERVICES IN THE UNITED STATES—A PROGRESS REPORT OF STATE PROGRAMS—Lee T. Muth, M.S.W., VA Hospital, Huntington, W. Va. Significant progress has been made in providing comprehensive after-care services during the past three and one-half years. A questionnaire of twelve questions was prepared and sent to 115 state mental hospitals covering all states except Alaska and Hawaii. The answers received from 70 hospitals, representing 40 states, form the basis of this report.

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*Abraham, W., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, Williams & Wilkins Company, 1956, p. 132.

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NEWS & NOTES

PEOPLE & PLACES

WASHINGTON, D. C.: **Dr. Dale C. Cameron,** who since last February had been assigned by the Public Health Service to the National Institute of Mental Health, has been appointed assistant superintendent of St. Elizabeths Hospital. **Dr. David W. Harris** became clinical director, and **Dr. William H. Dobbs** replaced Dr. Harris as chief of service at the Dix Pavilion.

HERE & THERE: **Dr. Leslie A. Osborn,** director of the Division of Mental Hygiene, Wisconsin Department of Public Welfare since 1950, has moved to Omaha, Neb., to become head of the Swanson Children's Clinic and professor of psychiatry at the University of Nebraska College of Medicine.

Robert W. Parkin, R.N., has been named director of nursing at Central State Hospital, Lakeland, Ky.

On October 1, **Dr. Milton H. Kibbe,** formerly clinical director of Lynchburg Training School, Va., became the superintendent of Petersburg Training School in Virginia.

Delaware State Hospital at Farnhurst has a new acting clinical director. He is **Dr. Kurt Anstreicher,** a staff member since 1954.

C. Lindley Jackson was appointed administrator of Cleveland State Hospital, Cleveland, Ohio. Mr. Jackson was formerly administrator of Hawthornden State Hospital, Macedonia, Ohio.

Upon the recent retirement of **Mrs. Florence S. Burns, Mrs. Irene B. Miller** of New York took over the job of program director of the Committee on Careers, National League for Nursing, New York.

Dr. Virginia M. Love has been appointed medical director of the Lakeland Guidance Center in Riverdale, N. J.

Dr. Victor V. Anderson, a pioneer in the establishment of child guidance clinics in this country, died recently in Staatsburg, N. Y.

Dr. John A. Doering recently arrived in Coatesville, Pa., to assume his duties as manager of the local VA hospital. He succeeds **Dr. Earl P. Brannon,** who was transferred last summer to Augusta, Ga.

Dr. Simon Kwalwasser resigned his position as associate medical director, Hillside Hospital, Glen Oaks, N. Y., to enter full-time private practice.

Dr. T. Glyne Williams, formerly of Yale University, is the new commissioner of mental health in Oklahoma.

Dr. Edith Cserny became superintendent of Huntington (W. Va.) State Hospital.

Dr. William E. Schumacher was recently appointed chief of the Bureau of Mental Health for Maine.

Quarterly Hospital Professional Calendar

A.P.A. ANNUAL MEETINGS:

1961 May 8-12, Hotel Morrison, Chicago, Ill. (117th)
1962 May 7-11, Royal York Hotel, Toronto, Canada (118th)
1963 May 13-17, Ambassador Hotel, Los Angeles, Cal. (119th)

A.P.A. MENTAL HOSPITAL INSTITUTES:

1961 Oct. 16-19, Hotel Sheraton-Fontenelle, Omaha, Neb. (13th)
1962 Sept. 24-27, Hotel Americana, Miami Beach, Fla. (14th)

OTHER A.P.A. MEETINGS

A.P.A. Council Meeting, *December 2-3,* A.P.A. Central Office Washington, D. C.

OTHER PROFESSIONAL ORGANIZATIONS

National Association for Mental Health, Annual Meeting, *November 17-19,* Denver Hilton Hotel, Denver, Colo.

A.M.A. Council on Mental Health, Annual Conference of Mental Health Representatives of State Medical Associations, *November 18-19,* Chicago, Ill.

Academy of Religion and Mental Health, Annual Meeting, *January 18-20,* Arden House, Harriman, N. Y. (Inq. H. C. Meserve, Prog. Dir., 16 E. 34th St., New York 16, N. Y.)

Association for Research in Nervous & Mental Disease, Annual Meeting, *December 9-10,* New York. (Inq. Dr. R. J. Masselink, Sec., 700 W. 168th St., New York 32, N. Y.)

American Psychoanalytic Association, Fall Meeting, *December 9-11,* Biltmore Hotel, New York, N. Y.

Academy of Psychoanalysis, Mid-Winter Meeting, *December 10-11,* Biltmore Hotel, New York, N. Y.

American Association for the Advancement of Science, Annual Meeting, *December 26-31,* Biltmore & Commodore Hotels, co-headquarters, New York, N. Y.

International Conference of Social Work, *January 8-14,* Rome, Italy. (Inq. Ruth M. Williams, Exec. Off., 345 E. 46th St., N. Y. 17, N. Y.)

White House Conference on Aging, *January 9-12,* Washington, D. C.

Academy of Religion and Mental Health, Annual Meeting, *January 18-20,* Biltmore Hotel, New York, N. Y.

National Association of Private Psychiatric Hospitals, Annual Meeting, *January 23-24,* Safari Hotel, Scottsdale, Phoenix, Ariz.

American Group Psychotherapy Association, Annual Conference, *January 25-28,* Henry Hudson Hotel, New York, N. Y.

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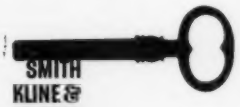
1. Kovitz, B.: Management of Psychotic Tension Symptoms with Trifluoperazine: A Preliminary Report, in *Trifluoperazine: Clinical and Pharmacological Aspects*, Philadelphia, Lea & Febiger, 1958, pp. 144-149.
2. Brooks, G.W.: Definite Ataractic Therapy in the Rehabilitation of Chronic Schizophrenic Patients: A Preliminary Report on the Use of Trifluoperazine, *ibid.*, pp. 54-61.



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*Diamond, O. K.: New York J. Med. 59:1792, 1959.

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1. Cameron, E.: The Use of Tofranil in the Aged, Canad. Psychiat. A. J. Special Supplement, **4**:S160, 1959. 2. Christe, P.: Indications for Tofranil in Geriatrics, Schweiz. med. Wchnschr. **90**:586, 1960. 3. Schmied, J., and Ziegler, A.: Tofranil in Geriatrics, Praxis **49**:472, 1960.

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